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INTRODUCTION

Individualized planning and care are at the heart of **Willie M.** services and have been since 1980 when, in response to the class action lawsuit, basic agreements were laid out. Today, the State continues to be held accountable for these agreements and is expected to show good faith and professionally capable efforts to provide appropriate services. Three of these requirements are to:

- Provide habilitation services which are suited to the needs of each client and designed to increase his/her capability to live as independently as possible and to function effectively in the community
- Provide residential and other services in the least-restrictive, appropriate settings and therefore most normal that is possible for each client
- Provide services which are determined by the client's actual needs as defined and recorded in a Treatment/Habilitation Plan rather than services and placements selected only because they are available **(See Appendices A and B)**

Habilitation Services

Habilitation services are education, training, care and specialized therapies which are meant to help each child progress as much as he[1] is able. It is a much broader focus than services traditionally thought of as mental health services. Progress for one child can be very different from that of another, and measuring that progress will be different too.

This idea is also different from the idea of curing each child. The word **cure** implies that there is a disease to be treated and gotten over. It also implies that health will be restored by doctors and nurses. The broader point of view encouraged here is one that looks beyond illness to include everything in the child's life that helps or hurts his ability to lead, what is for him, a more successful life.

Least Restrictive Services and Most Normal Services

We are to provide **least restrictive** services, including residential, for each client. When we think of **most normal**, we are trying to determine what will best fit the child, given his background and experience. As we determine what is least restrictive and most normal for each child, we must also think about the child's need for safety and the safety of the community in which the child will live. It is in the child's best interest to feel safe from being out of control as well as to be out of harm's way.

All of our children may not be able to live independently in the community. Sometimes, for therapeutic reasons, they may need to live in supervised settings. We are, however, committed to helping each of them find and make his own place in this world. That is why a range of services exist: from family or independent living to group care; from special education to college or job training; from psychotherapy to learning how to play. We want each child to live as safely and productively as possible with people they care about and who care about them.

[1]The pronoun “he” will most often be used for ease of reading; approximately 80% of **Willie M.** clients are male.

Needed Services

Third, we are to provide services which each child actually needs and not choose services because they happen to be available. The focus is on **essential needs**. These are fundamental or basic needs which are "required in order for the child to overcome or cope with the problems that led to eligibility, to prepare for adulthood and to acquire and maintain life skills consistent with his/her potential and capabilities." *(*From *Elements of Appropriate Services for **Willie M.** Clients)*

The services must fit the child, not the other way around. In the real world, this concept can be difficult to accomplish. Usually there are too few resources for children, and service providers may become used to thinking about and advocating for whatever placements **or services** may currently exist. However, new services should be developed or existing services tailored to match the individual needs of each client when it is determined that this is in the best interest of the child. This requires a creative approach and willingness to be innovative in customizing services to match needs.

Different Point of View

Using individual strengths and needs as the basis for planning services for children and their families is a way of thinking that increases collaboration with clients and drives the development of an expanded array of accessible services. The guiding principle behind the strengths and needs-based approach is that each service must be designed to meet a specific need and build on a specific strength. An important advantage of the strengths and needs-based approach is that it can be understood by children and their families.

The idea of providing services developed to meet a child's needs requires a point of view which may differ from traditional therapies in several ways. One way that it differs is the extent to which the strengths of the client are identified and built upon. The other way that this view point differs is by examining the risk and protective factors faced by the client.

Look at Strengths

Finding strengths is not always easy for a number of reasons. Many children have failed in school for years and seem to have had little success at anything. Families oftentimes face insurmountable problems associated with poverty, lack of opportunity, substance abuse, etc., so that they may appear to have few strengths as well. Being overly aware of a child's/family's deficits may cause difficulty in seeing strengths.

It is critical that we take a step back, identify strengths, determine needs and develop plans which support each clients and families strengths. We should then evaluate whether the supports and strategies developed in the plans are indeed helping the child make progress in life.

Look at Risk and Protective Factors

Another way in which this viewpoint may differ from the traditional is its focus on supporting those elements in the child, the family and community life which may help protect the child from the risks faced every day. Many times these risks or risk factors may interfere with the progress the child and family is attempting to make.

Risk factors include such things as pre-natal or birth complications, physical/ neurological problems, family stress and other problems such as neglect or physical/sexual abuse, parental problems, problems

with friends, mental health problems, substance abuse, poor school performance, and delinquent behavior/ charges.

Protective factors which can counteract the effects of risk factors include home as a predictable place, the child feeling loved by the parent and loving them, getting along with others, feelings of competence and confidence, doing well in school, and having a supportive relationship with an adult. Protective factors must be identified and supported through the treatment plan process.

The involvement and oversight by psychiatrists, psychologists, clinical social workers and other clinicians are critical in assessing protective and risk factors and in guiding the development and implementation of treatment/habilitation plans. Family members and other team members are also an essential part of this process.

This kind of outlook, one that aims to provide services which are matched to the child's needs and one that focuses on strengths and resilience in the child's life, requires a willingness to be creative and responsive to change as well as paying attention to the *total 24-hour-a-day, 7-day-a-week life of each child and the child's family*. It is **truly** a commitment.

THE TREATMENT/HABILITATION PLANNING PROCESS

Habilitation Planning Team

Willie M. Case Managers have **primary** responsibility for seeing that *Treatment/ Habilitation Plans* (***T/HPs***) for the clients assigned to them are completed, monitored and updated as necessary. However, they cannot and should not plan, coordinate, and monitor services alone.

Treatment/ Habilitation Plans are created by a team of people working together, whose members also have other functions. They are usually the same people who may write their agencies' treatment or service plans for clients. This personal linkage helps to ensure that treatment or service plan goals and ***T/HP*** goals are consistent. The Team itself may serve as an interagency forum to assist **Willie M.** program units in developing services which are needed but not yet available. The Team, with the Case Manager facilitating, reviews plan updates and modifies strategies based on the client's progress or lack of thereof.

Case Manager's Roles

Case Managers bring together each client's Habilitation Planning Team, which consists of professionals and other persons involved in the child's life and service planning and delivery. It is the Case Managers who coordinate the efforts of the team in planning and updating the plan.

Case Managers also collect the service or program plans prepared by service providers, and make sure that they are consistent with the client's ***T/HP***. Case Managers have four primary roles:

1. Planning Role
2. Monitoring Role
3. Advocacy Role
4. Service Provision Role

1. Planning Role

Willie M. Case Managers have primary responsibility for developing and updating the ***T/HPs*** for the clients assigned to them. Case Managers see that the Treatment/Habilitation Planning Team includes the child and everyone involved in that child's care. They are responsible for involving the client, his family, and/or guardians or legal custodians in the planning process, and guiding them through it. Part of the planning role includes the need to consider cultural and other relevant issues in matching service providers to clients and families. Case Managers initiate the creation of each client's Treatment/Habilitation Planning Team, and they coordinate the efforts of the team in plan development and plan update. They collect and monitor the treatment/program plans prepared by service providers, and they ensure their consistency with the client's ***T/HP***.

2. Monitoring Role

Willie M. Case Managers monitor the progress which their assigned clients make in achieving the goals which are specified in their ***T/HPs***. Case Managers initiate plan updates at the intervals required by the Division.

Planned monitoring of services requires that case managers develop the self-confidence to hold other people (from community supports and a variety of agencies) accountable for services.

Once a plan has been developed, its effectiveness in meeting the child's needs must be regularly assessed (at least monthly). The services for the child must be adjusted as needed by adding unanticipated services, deleting services, or providing services in different ways. The quantity of services and how long they are provided, will depend on how effectively they respond to the child's identified needs.

3. Advocacy Role

Willie M. Case Managers have primary responsibility for advocating for clients within and outside the service system. Their success in this regard is, in large measure, determined by their understanding of the child and by the strategies they use to accomplish their goal of seeing to it that the client gets what he needs. Developing strong intra-agency **and** inter-agency relationships with the people who can and will provide services to their assigned clients should be one of the Case Managers' main advocacy strategies (e.g., legal and social service systems).

4. Service Provision Role

The treatment provider or service provision role and the case management role are two separate and distinct roles. To the extent that **Willie M.** Case Managers have to perform both roles, they and their supervisors should be sensitive to the demands and boundaries of each. Care must be taken to ensure that the planning, monitoring and, especially, advocacy roles do not conflict with a service provision role.

Participants in the Planning Process

There are several groups of individuals, in addition to Case Managers, which need to be part of the habilitation planning process.

Client and Family

The first group is the client, his family, and/or guardians or legal custodians. Involvement of the guardian or legal custodian in the habilitation planning process is mandatory and unless there are pressing clinical reasons or unless parental rights have been terminated, involvement of the client and his family is strongly encouraged. This can be true even for a child who will not return home to live. Often that child will want and need an ongoing relationship with his family, and it is up to the Treatment/Habilitation Team to assist in ways that make sense for the child.

The assigned Case Manager, along with the family and Team, have the responsibility to determine how the client, his family, and the guardian or legal custodian are to be involved in the planning process and to guide them through it.

Sometimes the child's parent, guardian or advocate may strongly disagree with or contest the needs assessment, the ***T/HP***, the services, the placement, or other elements of the child's care. The Case Manager should make every effort to engage them in a negotiation process. They also have the responsibility to make families aware of their rights to *Contested Case Procedures*[2] and assist them as needed.

[2] Specific process and procedures are outlined in North Carolina Administrative Code, Section .7000 and in the booklet "How are Disagreements Resolved in the **Willie M.** Program."

Other Community Adults

It can also be very helpful to include in treatment planning, people from the child's **natural community** who may be able to provide support and may help protect the child from risk factors. These people may be extended family members, neighbors, church members, or other adults from the child's world who are important to him.

Clinicians

As we noted earlier, clinicians are also very important members of the Habilitation Team. Their diagnostic evaluations and recommendations for treatment and care should help focus planning so that the child can make measurable progress toward accomplishing goals.

Other Professional and Para-Professional Staff

Other professionals and para-professionals who are involved with the child and/or family should be included, such as in-home support staff and mentors. They can provide valuable input into the planning process.

Educators

Because the Department of Public Instruction was a defendant in the **Willie M.** lawsuit, the Local Education Agency, or LEA, the Program Administrator for Exceptional Children or the official designee must be involved for all clients who are of school age and for those over sixteen (16) years of age who have not officially stopped attending school.

Representatives From Other Responsible Agencies

Members of other public and private agencies who have or who may have a responsibility to provide habilitation services to the client also need to be included on the Team. It is important to encourage all those who have knowledge of the child and family and who can be active participants in the process to be a part of the child's Team.

Others Who May Be Involved

Division of Adult Mental Health/Developmental Disabilities/ Substance Abuse Services

An Adult Mental Health, Developmental Disabilities, or Substance Abuse Services representative is needed for planning the transition to adult services. Planning for this transition should begin at least when the child is 16 and even younger if needed.

Developmental Disabilities

The Developmental Disabilities Coordinator or representative is needed if the child's functioning level falls within this range or if the child is otherwise eligible for these services. Involvement by the DD system, through the Single Portal coordinator, is required if the client is developmentally disabled. For transition planning, the single portal coordinator should be involved beginning at age 16.

Program/Residential Representatives

If the child attends a program such as day treatment, or lives in an out-of-home therapeutic setting, a representative of that program should be part of the Team. Participation by people working with children in a hospital, re-education program, group home, or training school (if in the custody of the Division of Youth Services), is also needed. In order for plans to be effective, both community and institutional personnel should be closely involved in their development and in agreement as to how and when plans are to be implemented.

Substance Abuse

An identified Substance Abuse Worker should be included if this is a problem area for the client.

Court Counselor/Probation Officer

The Juvenile Court Counselor or the Adult Probation Officer (depending on court assignment) should also be included if the client has contact with the juvenile or adult justice systems.

Guardian ad Litem

If the child has been adjudicated neglected or abused, the Guardian *ad Litem* needs to be part of the Team and can be a very effective advocate for the client.

Department of Social Services

A Social Worker from the local Department of Social Services must be involved if DSS is the legal custodian. There should also be DSS participation if the child is involved with the Protective Services unit.

Vocational Rehabilitation

If the Client is a Vocational Rehabilitation client or is sixteen (16) years old and vocational needs are to be considered, the Vocational Rehabilitation counselor and/or the local school system's vocational education counselor should be included.

Health Department

The local health department representative may be part of the Team.

Private Practice Professionals

Others who may be represented on the Habilitation Team are professionals in the private sector such as physicians, psychiatrists, psychologists, and clinical social workers.

This is quite an extensive list of people who should be considered a part of the child's Team and Case Managers are expected to seek participation from every agency serving the child. This includes individuals who most likely will be serving the child to those who know and are currently involved with the child.

Teamwork

Because planning is such an important part of our care for these children, it is necessary to involve caregivers in the entire process. Each child deserves to have a team of people who are knowledgeable about his needs and who are willing to work cooperatively in his best interest. Workers can be invested in the child only to the extent that they see themselves as part of the Team. Good communication between

the Case Manager and other Team members is essential. Team members need to make sure that necessary releases of information are signed according to confidentiality laws and rules.

The Case Manager acts as the nucleus for all information presented and is the one person expected to have a holistic view of the child and family. This holistic view should be reflected throughout the plan. It is important for the Case Manager and the rest of the ***T/HP*** Team to develop whatever working relationship is most efficient and effective. Regardless of the approach taken, team members are the primary consultants to the Case Manager. For example, the education member may take the lead in developing and updating the education goals for the client, since the local education agency has the legal responsibility for providing education to all clients. Residential staff may take the lead in developing goals and plans of care in their residential facility.

It is up to the case manager to resolve any disputes that may arise and work with all Team members to ensure a well-coordinated and holistic ***T/HP*** is implemented.

The Importance of Negotiation

Sometimes interagency (or intra-agency) disputes over plan development or plan implementation may occur. If Team members are working at cross purposes, then everybody loses--most of all the child. It is important for disputes to be negotiated and resolved among ***T/HP*** Team members whenever possible. Because the Case Manager leads the team, he or she should be involved first. Good interagency relationships will help in the resolution of conflicts at this level.

Administrative supervisors, up to and including Area Directors and Superintendents, are responsible at the local level for helping Case Managers negotiate difficult inter-agency and intra-agency issues. The Division's **Willie M.** Regional Service Managers and the Department of Public Instruction's **Willie M.** Education Consultants are available to assist Case Managers, Program Administrators and their supervisors. Ultimately the DHHS and DPI **Willie M.** Sections can get involved if things cannot be settled locally.

Just as the ***T/HP*** is at the heart of our care for **Willie M.** clients, so are working relationships which remain focused on the essential needs of the client at the heart of the ***T/HP*** process.

Summary

Involvement between the client and the family (and/or guardians) is essential; it must be initiated at the beginning of the planning process by the Case Manager and maintained throughout the process unless there are clinical reasons for not doing so. The Case Manager establishes and maintains a Treatment/Habilitation Planning Team for each client and coordinates the activities of the team at all stages of the planning process. Additionally, the Case Manager seeks consultation from clinicians for evaluations and treatment recommendations.

Because all members of a client's Treatment/Habilitation Planning Team are important, the Case Manager requests that each participate and approve the initial habilitation plan, reviews and updates. Consequently, an effective working relationship among Team members is vital to the process.

Service and program plans developed by service providers are to be consistent with the goals which have been developed in the client's ***T/HP***. Since all the pieces of the service plans must fit together, there must be good communication among Team members.

The Planning Process

Look Into the Future

When the planning process begins, the first thing the Team (including the child and his family) must do is look into the future and try to figure out what this client's life **can** be like at age 18. Then all aspects of care for the child must help point him toward that life. We begin by making plans. Our goal is to help prepare the child for the reasonably expected life and problems he will encounter as a young adult and to help him acquire and maintain life skills consistent with his potential and capabilities.

For this type of planning to be successful, it needs to be organized, realistic and measurable. The more the Team is able to keep itself focused in this way, the better able it is to effectively use whatever time remains before the child turns 18 in order to prepare him for life as an adult.

The 24-Hour A Day/Seven-Day-A-Week Life of the Child

Given the nature of the children we deal with in **Willie M.**, we must pay attention to the total 24-hour-a-day, 7-day-a-week life of the child. To make sure that we do this, seven (7) primary areas or **Life Areas** must be examined and planned for:

- educational
- health
- housing/residential
- social
- vocational
- behavioral
- crisis

If we are successful in addressing the strengths and problems in all these areas, then it is very likely we will not have overlooked any other significant or important pieces of the client's life.

Habilitation planning is organized around the child and family's strengths (or protective factors) as well as their preferences (lifestyle choices). These strengths and preferences should be utilized in an effort to achieve desired outcomes or goals. The strategies which define what team members will do are developed with the child and family and should reflect the types of interventions that will be implemented in order to assist the client in achieving his desired outcomes (formerly "objectives" and "goals").

It is important to keep this process as simple and focused as possible. This is not an easy task, but the more systematic we can be, and the more focused we remain, the better the results can be for the client.

Focus on Strengths

Again, it is vital to remember to take a strength-based approach or point of view in the planning process. Because these children have very significant problems, it is easy to look only at those problems and at what must be done to **get rid** of them. These children, however, are going to continue to live in a less than perfect world. They must be able to take the difficulties they face and deal with them in ways which allow them to succeed in life. That is, they need to be resilient enough to **roll with the punches** that life provides. We embrace protective factors, strengths, and preferences in our treatment planning because it is these elements which will lead to resilience.

Identify the Child's Strengths And Preferences

When we think about strengths and preferences, it is important to remember to think of them in terms of the client --not the staff, family, or agency strengths or preferences. Strengths which assist the client in coping with life should be supported and developed.

Identify the Child's Needs

Needs are derived from those issues which interfere with a client being able to cope successfully with the demands of his environment or learn what he must do differently in order to succeed in his environment. Needs are identified once we learn the child's strengths and preferences as well as his problems. We must ask ourselves, *"What needs to happen to support the child's strengths and help him overcome risk factors?"*

Over time we have become less able to see children's needs because of the lack of services in our communities. Our view of children's needs has been narrowed to fit the services we know are available. Seeing children's needs requires careful observation and listening to the child and other Team members.

Remember, identifying needs is a type of brainstorming activity. Do not limit yourself at this stage by thinking about possible services while developing a list of needs. This will only hinder your ability to think creatively and, in the end, your ability to work effectively for your client.

Assess Needs

There are three steps to assessing needs:

1. Review all available evaluation information and develop a comprehensive assessment package

2. Translate strengths and preferences as well as issues interfering with their development into simple statements of need

3. Present the list of needs in an organized fashion

1. Review All Available Evaluation Information

The first step is to collect, review, summarize and analyze all available information. In large part, the information will have been gathered through completion of the Assessment and Outcome Instrument (AOI)[3]. Also, unless the child is a new client, the appropriateness review is to be completed prior to the treatment planning process. This will give us some idea of where the planning should be strengthened[4]. If any gaps in information remain, assign tasks to complete additional diagnostic testing or other evaluations as necessary. Set time lines for the completion of needed assessments and monitor to ensure that the assessments are completed as planned.

Analyzing the information obtained from the AOI and other sources provides data from which a list of strengths, preferences and needs can be developed. **(See Appendix B)**

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[3] The AOI is a comprehensive system of data gathering and assessment designed by the Evaluation Branch of the **Willie M.** Section which is to be completed as the first step in developing the *Treatment/Habilitation Plan.*

[4] The Appropriateness Review was developed by the **Willie M.** Section to address the appropriateness of services component of the mandate. This review is to be completed on an annual basis prior to the treatment/habilitation planning process. It has been suggested that a logical sequence is for the Appropriateness Review to be completed following the AOI; however, this is not a requirement.

2. Translate Strengths, Preferences and Issues Into Simple Statements of Need

This is the second step of the needs assessment process. We are responsible for taking care of client's **essential needs**. Essential needs are those required in order for the child to overcome or cope with the problems that led to clientship, to prepare for adulthood and to acquire and maintain life skills consistent with his/her potential and capabilities." (From *Elements of Appropriate Services for **Willie M.** Clients*)

To do this we determine what strengths and protective factors the client possess which help guard against risks. Then we must decide what should be done to support those strengths and, at the same time, must determine what factors create risk to the child. We then decide what must be done to eliminate, reduce or prevent those risks from occurring.

Once the child's needs have been identified, each need is matched to services and these services should build on the child's strengths. This is a step-by-step process of tailoring each service to meet each need, accompanying goal, and objectives. Services should be generated based on needs without being limited to existing services. Access to community-based services is important. Services must be within reach, compatible with the family's ethnic and sociocultural background, thoroughly explained to the child and family/guardian, and timely.

3. Present the Needs in an Organized Fashion

The last part of the assessment process requires presenting the needs in an organized fashion. The ***T/HP*** forms are meant to assist us in writing these down in an orderly manner. It is also critical to prioritize the needs identified in the assessment process with the client and his family.

Set Desired Outcomes Based on Needs

The planning process involves identifying strengths, preferences and risks, determining needs, formulating desired outcomes and then developing strategies.

Once needs are identified, the next step is to set desired outcomes. The concept of desired outcomes includes the concepts of goals and objectives. That is, desired outcomes refer to end results which can be short and long term, global and intermediate.

General Rules for Stating Desired Outcomes

The following general rules apply for stating client desired outcomes:

- Address each needs statement
- Set reasonable expectations
- Think in terms of both short-term STEPS and longer term END RESULTS.
- State desired outcomes simply and in such a way that they are measurable
- Include time frames for achieving desired outcomes, goals and objectives

Develop Strategies

Once we are clear about what desired outcomes the client would like to accomplish, the final step is to develop the strategies or interventions team members must implement in order to assist the client in

achieving his goals. **Desired outcomes** define what the client will accomplish; the **strategy** defines what **team members** will do to help the client accomplish his desired outcomes. Strategy statements reflect the types of interventions to be implemented including the frequency of interventions.

It is important to be very clear about who is responsible for carrying out a particular strategy or support and to make sure that progress, or lack of it, is well documented according to agency guidelines, along with time frames for implementing and accomplishing strategies.

Set Backup and Crisis Plans

Back up plans must be included as part of any good treatment/habilitation process. The best laid plans will go awry no matter how much we prepare ahead of time. In order to avoid last-minute changes which are upsetting to the lives of our clients, it is important to think about and have back up plans available if the initial plan is delayed or falls short.

By their very nature, **Willie M.** clients are prone to behaviors which generate crises in their lives and in the lives of the people around them. Therefore, it is **always** important to expect and prepare for crises by developing strategies in advance of them.

Summary

If you actively work as one member of a team of committed individuals, and, if you remember to translate strengths and preferences into needs, needs into desired outcomes, and desired outcomes into strategies which are carried out in an organized way, you will be doing your part in assisting your client to improve his life. And, of course, that's what it's really all about.

The children we serve come to us with lives filled with pain, despair, and complex problems as well as strengths, which may seem hidden at first. Working with other service providers to help these children better their lives is just as complex.

When we see ourselves as one part of a Team in which all are valued contributors to the care of the children, and in which everyone works together, then we are truly doing **whatever it takes** to care appropriately for each and every one of our kids.

THE TREATMENT/HABILITATION PLAN & FORM INSTRUCTIONS

Introduction

In order to streamline the use of the T/HP, representatives of the CAP-MR/DD Branch and **Thomas S.** and **Willie M.** Sections have worked together to revise the ***Treatment/ Habilitation Plan*** (***T/HP***). The revised version for use with **Willie M.** clients can be adopted beginning July 1, 1998, and is required for use by all on September 1, 1998. Rules governing the requirements for T/HP planning and the provision of services for **Willie M.** clients are found in the North Carolina Administrative Code, Section .7000 - Services for Eligible Assaultive and Violent Children and Adolescents.

At a minimum, the ***T/HP*** is to be written in such a way that it represents a global understanding of the child's strengths, needs and desired outcomes. Oftentimes separate service or treatment plans are also developed for the discrete services identified within the ***T/HP***. These separate plans should identify and expand upon strengths, goals, objectives, strategies, client outcomes and time frames identified in the ***T/HP.*** In some cases, separate plans may be required by other funding sources, such as Medicaid or the service provider. When these plans exist or are to be developed, they should be referred to in the ***T/HP***. For example, if the child is identified with special education needs at school, then the Individualized Education Plan or IEP will be one of the service plans referred to in the ***T/HP***.

When the ***T/HP*** is being used as the only operating plan, then the ***T/HP*** must be written in more detail to include the strengths, needs, desired outcomes, strategies, and time frames that would otherwise be included in a separate service or treatment plan. Remember, the details need to be somewhere, either in the ***T/HP*** or in a separate service plan which coordinates with the ***T/HP***.

It is important to understand that the development of the ***T/HP*** is a process, not just a meeting and a piece of paper. This process includes a thorough assessment of the child and his family to determine strengths and needs. This is accomplished through the completion of the AOI and other assessment instruments, in addition to discussions or interviews with the child, the family and other significant individuals and/or agencies who are involved in the child's life. Completing a thorough assessment and developing a relationship with the child and his/her family are the fundamental building blocks to developing a "good" treatment plan. This can be a very time consuming process as it is not unusual for a thorough ***T/HP*** to take at least 12-18 hours to complete. But the time spent during this process will ultimately pay off with a solid and coordinated plan to work with the child and his family.

Time Frames for Treatment/Habilitation Planning

Planning

In general, service planning begins when a child is found eligible for services in the **Willie M.** program and continues throughout our involvement with the child, which can be until he/she turns age 18 and "ages out" of the program. (See Rule .7012).

Providing Services

Expectations for providing services are set forth in North Carolina Administrative Code .7013 and are summarized as follows:

- that appropriate services to meet **essential needs** will be provided immediately to the extent they are available, and;

- that needed placements and services which do not exist or are not available, will be **developed and implemented within 30 days** after the ***T/HP*** is developed. If needed residential services will not be available within the required 30 days, or do not exist and have to be developed, then the area program and the legally responsible person **will agree on a specified time frame** by which the services will be developed and provided. They will also agree on what services are to be provided in the interim.

Documenting Plans

A completed ***T/HP*** is due within **thirty days** of notice of eligibility, and must be reviewed and updated *at least* **annually**. Nevertheless, the ***T/HP*** should always be updated based upon the need for service change and/or emerging clinical issues as opposed to relying upon these time frames alone.

In 1997, the **Willie M.** Section began assigning permanent ***T/HP*** annual review dates for all clients found eligible for services. These fixed dates are used to generate due dates for local programs to complete Assessment and Outcome Instruments (AOI) and ***T/HPs***. In general, the permanent annual review date for a **Willie M.** client is 13 months following notice of eligibility.

♦ ***T/HP*** **AT 30 DAYS FROM ELIGIBILITY** - A written version of the ***T/HP*** must be completed within 30 days of notice of eligibility. There are two documentation procedures to complete.

1. **Paper copy** - Send two copies to the **Willie M.** Section within one month of completion. One copy will be kept in the Section office, and the second copy will be forwarded to the assigned Regional Service Manager (RSM). (Note that only one copy is needed if the RSM assigned to your area program is located in the Section office.)

- If the child is already an area program client with an active service plan, then that plan may be updated and used until the ***T/HP*** is due.

- If the newly eligible child is also new to the area program, Division procedures require that a service plan be completed on the day of admission to the area program. For **Willie M.** clients, the options are:

  a) Use the new standardized form (effective September 1, 1998) until the ***T/HP*** is due, **or**

  b) Use the ***T/HP*** form, completing the Face Sheet, any applicable Life Area (required Life Areas should still be addressed on the form even if just to indicate scheduled or anticipated assessment dates), the Case Management Plan and obtaining required signatures, **or**

  c) Follow your area program's rules (must meet Medicaid standards).

2. **Willie M. Information System (WMIS)** - In the Client Information System (CIS), enter a 730 activity code showing when the ***T/HP*** meeting was held.

- **INCOMPLETE *T/HP* AT 30 DAYS** - If the ***T/HP*** is incomplete at 30 days, you must still turn it in to the Section according to the schedule for a complete ***T/HP***. Complete the unfinished ***T/HP*** within the next 60 days (maximum of 90 days from notice of eligibility determination). An initial ***T/HP*** should only be incomplete after 30 days if the child is completely unknown to the area program and there are significant assessment questions that need to be answered before developing a comprehensive ***T/HP*** (see below).

  An incomplete ***T/HP*** must still include a complete Face Sheet, any Life Areas that apply, the Case Management Plan, and the required signatures. Even if a plan is determined to be incomplete, required Life Areas should still be addressed on the form even if just to indicate scheduled or anticipated assessment dates.

  The ***T/HP*** is considered incomplete at the 30 day submission if:

  - One or more required Life Areas are not entirely complete due to lack of assessment information **and**
  - The plan, or a significant portion of it, calls for additional assessments to be completed in a number of areas **or**
  - The treatment/habilitation planning team agrees that the initial plan is weak or falls short of what is needed and that additional work needs to be done to develop services, strategies, etc.

  In other words, in some instances the team may make a **judgment call** about the completeness of the plan, and the team has to honestly ask itself if the plan is **appropriate** and meets the standards expected for a **Willie M.** child. Before determining that the ***T/HP*** at 30 days is incomplete, consult with the DHHS **Willie M.** Regional Service Manager.

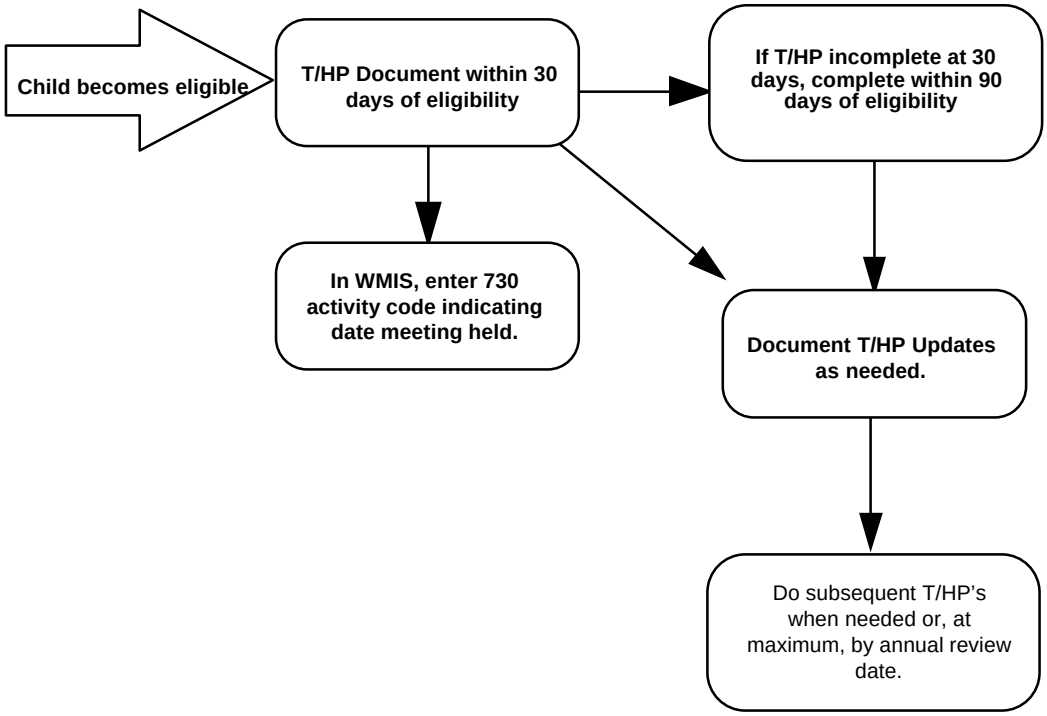
- **SUBSEQUENT *T/HP*'S** - ***T/HPs*** are to be completed at least once per year at the annual review date. However, the ***T/HP*** should always be updated based on the need for service change and emerging clinical issues as opposed to these time frames alone (see following section on updates). One year is the maximum amount of time between plans.

  Other factors to be considered in determining subsequent ***T/HP*** review dates include:

  - clinical or other treatment needs of the child
  - current age of client which might affect when the next ***T/HP*** review should occur (e.g., child will be turning sixteen in 9 months, etc.)
  - anticipated changes or major events/transitions which would have a significant effect on services/plans (e.g. residential move anticipated; low motivation for school continuation with client who will soon turn sixteen; or major family problems such as illness, etc.)

Please note that the ***T/HP*** must always be reviewed on the annual review date, regardless of when the plan was last completed or updated. This can be done by reviewing the plan and obtaining a new signature page if the plan was just recently changed.

T/HP Documentation is illustrated by the following chart:



Common Elements for All T/HPs

- Completed ***T/HPs*** (plans with final approval) are due to the **Willie M.** Section no later than **one month** from the expected date of completion.

- ***T/HPs*** must reflect that services to meet **essential needs** are provided immediately to the extent available.

- ***T/HPs*** must reflect that needed placements and services, other than residential, which do not exist or are not available, are *developed and implemented within 30 days after the **T/HP** is developed, unless a longer period is agreed upon by the legally responsible person and the area program or contract agency*.

- Documentation of transition planning shall occur at the regularly scheduled Treatment/Habilitation Planning Team meeting closest to the client's sixteenth birthday, with subsequent transition ***Updates*** according to the time frame outlined above.

- ***T/HPs*** are to be reviewed and fully updated on the **assigned annual review date** and when needed or clinically indicated.

Organization of the Revised Treatment/Habilitation Plan

Enter the client's name, area program record number and **Willie M.** unique identifier on each page.

Face Sheet

1. T/HP Meeting Date

Enter date meeting held.

2. Thomas S. FBD

For **Thomas S.** only.

3. Willie M. Eligibility Date

The official eligibility date is the date Activity Code 950 is entered into the **Willie M.** Information System (WMIS) by the **Willie M.** Section.

4. Plan Approved By/Plan Approval Date

Enter the approval date. For **Willie M.**, the approval date is the date of the last planning team member's signature; however, if all team members have not signed **within two weeks** of the T/HP meeting, the date when the last **mandatory** signature is obtained may be used. (Mandatory signatures are those of the client, parent(s)/guardian(s), the Case Manager and school representative.)

5. Name (as it appears on Medicaid Card)

If no Medicaid card, enter client's legal name as written on eligibility notice.

6. Preferred Name

Enter any nickname.

7. Area Program

Enter the responsible home area program (area program in which the client's legal residence, as defined by the guardian's legal residence, is located). If this is a Carolina Alternatives site, you may indicate this by putting "(CA)" after the name of the program.

8. Case Manager

Enter the name of the client's primary Case Manager.

9. Record Number/Unique ID

Enter the area program's record number for the client and the **Willie M.** unique identifier. The unique identifier is the first three letters of the last name, the first initial, and the client's date of birth. (e.g. ABUJ102783)

10. Date of Birth

Enter Month, Day, and Year (as identified on the Medicaid card if there is one).

11. Address

Enter street name and number of the client's complete legal address.

12. Phone

Enter client's complete legal residence telephone number (including area code).

13. City, State, Zip

Enter for the client's legal address.

14. Medicaid County

Enter county of Medicaid eligibility.

15. Gender

Check **F** for female or **M** for male.

16. Medicaid ID#

If applicable, enter client's Medicaid number as identified on Medicaid card.

17. Race/Ethnicity

Check one as appropriate.

- **W**=White
- **H**=Hispanic
- **A**=Asian
- **AA**=African American
- **NA**=Native American
- **O**=Other

18. Type Of Plan

Check appropriate box:

Initial Plan of Care Check this box if this is the first ***T/HP*** completed for this client.

Continued/Update Check this box if the plan is *not* the first ***T/HP*** completed for this client.

Transition Check this box if this is the plan for what happens when the client becomes age 18. A formal Transition Plan should be written around the child's sixteenth birthday and continue to be updated at least annually. (If the child is found eligible for services at age 16 and/or older, the Transition Plan and the Initial Plan may be one and the same.)

19. CAP-MR/DD Population

For CAP-MR/DD clients only.

20. Special Funding

Check the appropriate block(s) for source or sources of funding for clients needs.

Thomas S. (Prospective) **Thomas S.** only.
Thomas S. (Confirmed) **Thomas S.** only.
Willie M. This is funding made available to **Willie M.** clients. The State will reimburse area programs each month for services provided to **Willie M.** clients based upon an approved budget for the area program or contractor.

21. Residency

For **Willie M.** clients, check the box for "Other"[5] and fill in the type of residency according to the **WMIS** Living Situation Code:

[5] If the child is living at home, instead you may check "Private home with Natural Family." If the child is living in a Foster or Therapeutic Home, you may check "AFL/Foster Care/Therapeutic Home."

DON'T KNOW	GROUP HOME (1-3 BEDS)	TRAINING SCHOOL
AT HOME	GROUP HOME (4 OR MORE BEDS)	ADULT CORRECTIONAL
CHILD LIVES ON OWN	NON-SECURE GROUP RTC	HOMELESS
FOSTER HOME	CAMP PROGRAM	OTHER
THERAPEUTIC HOME	SECURE NON-MEDICAL RTC	JUVENILE DETENTION
ONE CHILD PROGRAM	HOSPITAL	ADULT JAIL

22. Diagnosis Code And Diagnoses

Include **all** DSM-IV diagnoses/codes that apply. Put a "P" beside the Primary Diagnosis.

- Axis I represents Clinical Disorders and Other Conditions That May Be a Focus of Clinical Attention (V codes)
- Axis II represents Personality Disorders/Mental Retardation
- Axis III represents General Medical Conditions
- Axis IV represents Psychosocial and Environmental Problems
- Axis V represents Global Assessment of Functioning

	If no disorder is present:	*If deferred pending gathering additional information:*
Axis I	V71.09	799.9
Axis II	V71.09	799.9
Axis III	Write "None"	Write "Deferred"

It is important to **review diagnoses and revise or update them** as appropriate when completing new PLANS. Whenever the intention has been given to **rule out** a diagnosis, the next PLAN should include that diagnosis as confirmed, or it should have been **ruled out** and should no longer appear on the PLAN.

23. Contact Person

- For an individual 18 year's old and older or a legally emancipated minor -

  Check "next of kin," and write in that person's relationship to the client.

- For a minor child -

  Check "legally responsible person."

  If the contact person is the child's parent, enter "*parent*" for "*type of relationship."*

  If the child is in DSS custody, enter "DSS custody" as type of relationship and, for date of action, enter the date of adjudication if the child has been adjudicated abused, neglected or dependent.

List name, address, and telephone number(s) of the Contact person.

24. Participants in Plan Development

Enter all individuals who were involved or assisted with this plan, i.e. the client, family, guardian, case manager, other service personnel and significant others.

25. Life Areas

Check all Life Areas addressed in the Plan. Life Areas **1-6** and **9** must be addressed for all **Willie M.** clients, except for those clients under the age of 14 for whom Life Area 2 (Vocation/Day) would be considered not applicable. For those age 16 or older, Life Area 10 must be completed and consideration given to this area for any child between the ages of 14 and 16.

Assessments Page

1. Assessment Given, Dates and Results (Include AOI date(s)[6]

Enter any assessment used to identify desired outcomes for the client, the date given and the results. Information obtained from the AOI (Assessment and Outcome Instrument) should also be included here. Also to be identified are informal assessments which are used to develop a global picture of the client's risk and protective factors and an understanding of the adult life of which he or she is capable. This may or may not refer to formal testing or behavioral scales but should include informal assessments such as collecting, reviewing, summarizing and analyzing all information available. *IQ testing information should only be recorded here*, not elsewhere in the Plan.

If there isn't enough information available, under "Additional Questions to be Answered," note informal or formal evaluation tasks that will be completed to gain additional information.

2. Additional Questions to be Answered by Assessments and Type(s) of Future Assessments Needed

Enter any projected assessment(s) which may need to be completed in order to understand and address the child's needs, desired outcomes, and strategies.

3. Current Status or Update on Progress Achieved since Last Plan: (Include information on progress from child's last AOI

- If this is the first ***T/HP***, in a brief paragraph, describe the child and the child's environment.
- If this is not the first ***T/HP***, in a brief paragraph summarize the child's progress (or lack of it) in areas addressed in the previous Plan. Use the AOI to help with this.

4. Current Medications and Reasons for Taking Them

List all prescribed medications and over-the-counter medications taken routinely by the client at the time the plan is completed. Include dosage, frequency, route (method administered), and the reason the medication is being given.

5. LEA/SOP (The Educational Liaison can provide information for this section.)

LEA (Local Education Agency) This usually refers to the local school system in a community.

SOP (State Operated Program) This most often includes state operated programs within secure treatment programs, state psychiatric hospitals, Wright and Whitaker Schools, and training schools.

School Enter the name of the client's school.

Grade Enter the client's grade in school.

[6] The official AOI date is the date of the review that appears on Form 4 (FDA).

Exceptional Student? Enter a "Y" if the client has been **formally** identified by appropriate school procedures as a child **with special needs**. Enter "N" if not. (Approximately 95% of **Willie M.** clients in school are **formally** classified as children with special needs or exceptional.)

Formal identification means that the child has been determined to be one of:

> children who, because of permanent or temporary mental, physical or emotional handicaps, need special education, are unable to have all their educational needs met in a regular class without special education or related services, or are unable to be adequately educated in the public schools. It includes those who are academically gifted, autistic, behaviorally-emotionally handicapped, deaf-blind, hearing impaired, mentally handicapped, multi-handicapped, orthopedically impaired, other health impaired, pregnant, specific learning disabled, speech-language impaired, traumatic brain injured and visually impaired. (From *Procedures Governing Programs and Services for Children with Special Needs, 1993 Edition*)

Area of Exceptionality Enter the category into which the client's educational needs have been classified.

Year Identified Enter the year, **if known**, in which the client was first formally identified through school procedures as a client with special needs. If there have been additions or changes to the area of exceptionality since the original identification, note these in parentheses following the original date.

6. Individual Education Program (IEP)

When a child is formally identified as **special needs/exceptional**, an ***Individualized Education Program*** (***IEP***) must be developed by the school program serving the child. This ***IEP*** should be referred to in the ***Treatment/Habilitation Plan*** and a copy included in the client's school and medical record (at the area program).

> Each handicapped child's educational placement must be based on his or her Individualized Education Program. The Individualized Education Program for each child must include:
>
> - a statement of the child's present levels of educational performance;
> - a statement of annual goals;
> - a statement of short-term instructional objectives;
> - a statement of specific education and related services to be provided to the child;
> - a description of the extent to which the child will participate in a regular education program . . . and a description of the program to be provided;
> - the projected dates for initiation of services and the anticipated duration of services;
> - objective criteria, evaluation procedures, and schedule for instructional objectives are being achieved.
>
> The transition component shall include: a statement of the needed transition services for handicapped students beginning no later than age 16, and at a younger age to the extent appropriate; a statement, if appropriate, of interagency responsibility if a State or local agency, other than the public agency responsible for the student's education is responsible for providing or

paying for needed transition services; a statement that where a participating agency, other than the public agency responsible for the student's education, fails to provide agreed upon transition services contained in the Individualized Education Program, the public agency shall, as soon as possible, reconvene a meeting of the participants on the Individualized Education Program team to identify alternative strategies to meet the transition objectives that were included in the student's individualized Education Program and revise the IEP if necessary.
(From *Procedures Governing Programs and Services for Children with Special Needs, 1993 Edition*)

Current? Enter "Y" if the IEP is current, "N" if not. According to DPI requirements, the IEP must be developed within thirty (30) days after the child is determined to be in need of special education services. It is to be reviewed annually or whenever the need for change arises. Therefore, in determining whether the IEP is current, both the date of its completion and the child's current circumstances are taken into consideration.

Reviewed? Enter "Y" if the IEP was reviewed when this ***T/HP*** was written, enter "N" if not.

Transition Plan (14+) Enter "Y" if there is an appropriate transition component to the IEP for a client fourteen (14) years old and over, enter "N" if not. It is a federal requirement that children sixteen (16) and older have a transition statement in the IEP. However, according to the Report of the House Committee on Education and Labor on P.L. 101-476, for those students considered **at risk** of dropping out and for those significantly educationally handicapped by their condition, a transition planning process beginning at age fourteen (14) and even earlier, is crucial[7].

Individual Behavior Management Plan? Enter "Y" if there is an individual behavior management plan for this client in the educational setting, enter "N" if not. The expectation is that there will be such a plan for each **Willie M.** client if there are behaviors that impact educational/vocational development within the learning environment. Briefly describe the plan.

Crisis Plan? Enter "Y" if there is a plan for handling crises with this client in the educational setting, enter "N" if not. The expectation is that there will be such a plan for each **Willie M.** client. Briefly describe the plan.

Person Centered Plan Page

This Plan describes the way the client sees and evaluates him or herself and what he or she wants in life. The goal is to work with the client (as appropriate for age and abilities) so that the client can make choices about treatment. These choices should be honored to the extent possible through planning and service delivery. This specific, individualized plan serves as a basis for identifying the services and supports which will be necessary to help the client achieve personal objectives and goals.

1. Strengths

Strengths are those characteristics within the client and the client's environment which will both assist the client in achieving goals and in resisting factors which may put at risk the client's ability to lead the most productive life of which he or she is capable.

a. After inserting the client's name, list the strengths the client identifies within him or herself.

[7] From the *National Transition Network*, Spring 1993.

b. List those strengths identified by others close to the client such as family and guardian and other relevant team members.

2. Choices

Choices are those activities, items, and supports which are decided upon by or for the client.

a. After inserting the client's name, list those activities, items, and supports which the client may choose. For example, depending on the age and mental, physical and social abilities of the client, he or she may choose involvement with family, residence, work, educational opportunities, friends, leisure activities, and the service personnel with whom he wants to work. Again, depending on the age and abilities of the client, it may be appropriate for these things to be chosen for the client.

b. List those choices and decisions which others make for the client.

3. Current Preferences

List here the actual lifestyle choices which are more immediately desirable to the client. The client may have preferences for his or her involvement with family, residence, work, educational opportunities, friends, leisure activities, and the service personnel with whom he or she wants to work. Here, you reflect the desires of the client. The team may not agree with them, but should show respect for the client's desires by discussing them.

- **Non-Negotiable -** Non-negotiable issues are the lifestyle choices the client believes are necessary or essential for a reasonable quality of life. They would be considered stronger than preferences in that the client feels that they are "musts" for his life. If there is a reason why particular non-negotiable issues cannot or should not be implemented, these should addressed in the ***PLAN***.

- **Strong Preferences -** Those options or alternatives which the client believes are important and may make a major contribution to a reasonable quality of life but are not critical.

- **Highly Desirable -** Those choices which the client believes may improve the quality of life, but which are not critical nor major.

4. Long Term Desires

List the client' s aspirations for the future. For those children who are in the custody of DSS, this may be an appropriate place to discuss where the child wants to live, keeping in mind that what is listed here represents the client's long term desires, not necessarily what others might think best.

Individual's Life Chart Page

When completed, the Individual's Life Chart presents a chronological map of the significant events in the life of a client, from birth to present. It is important to include only those events that are especially important to understand the client and the client's strengths, protective and risk factors, and needs. Three basic categories of events may be considered in the life chart.

1. **Developmental Events** are those which describe gains or lack of progress in the individual's physical, motor, cognitive, language, social, or emotional growth.

2. **Environmental Events** are those occurring in the individual's circumstances or surroundings which have had negative or positive consequences on the client's growth and development (including changes within the family).

3. **Clinical/Academic Events** are those factors or events which have had either a direct impact on the individual's current handicapping condition or which have contributed to our understanding of the clinical and academic picture of the child. These are non-developmental in nature.

Think in terms of the major findings in the child's social history. The main idea is to convey those factors which have affected normal growth and development (**positively** and negatively) and either caused or contributed to the client' s current circumstances. **Include only those events which are believed to have had substantial impact** on the normal growth, development and/or current functioning of the individual. **The life chart is intended to chronicle the major events in the client's life, not to serve as a record of activities carried out by agencies.**

The emphasis on **protective factors**, which frequently translate into strengths for the child, is an important area of focus in our ***T/HP*** process. Remember to include life events or client capacities that have contributed to the child's **positive** growth and development.

For each event, include the exact or closely approximate date (month and year, minimally) and the individual's age. Describe the "significant life event" in phrases structured to present the intended information rather than in full grammatically correct sentences. In other words, the content is more important than the mode of delivery. Be brief and succinct, but thorough.

Distribution of the life chart is to be determined by the child's habilitation planning team, including the child and family.

Life Areas Page

1. Life Area Generally

Life Areas 1-6 and 9 must be addressed for all **Willie M.** clients, except for children under 14 for whom Life Area 2 (Vocation/Day) would be considered not applicable. For those age 16 or older, Life Area 10 (Transitional Services) must be completed and consideration given to this area for any child between the ages of 16 and 18. In order to determine each child's underlying needs, it is important to seek information and ask questions of the client, the family, ourselves and other team members which are designed to identify a child's **real** needs. Included under a discussion of each Life Area is a series of sample questions that might help uncover a child's needs in a particular area. **They are provided as samples and suggestions only, and are not intended to be exhaustive lists**. The feedback that is gathered through the Assessment and AOI about each life area should also provide very rich information about the child's underlying needs.

Life Area # 1: Living Arrangement/Housing/Residential

A **home** is a place, even if it is not the natural home, which provides a client with a safe, nurturing environment conducive to the achievement of all of his other goals.

- Where is the child now living?
- With whom does the child have a positive, healthy relationship?
- Is the child physically and emotionally safe in the home?

- What does he need in order to feel safe in the home?
- If the child is in a residential setting out of the home, is the long term plan to return him to his home? If not where?
- What does the child need to transition effectively into his or her home or other stable residential setting?
- Has the child experienced multiple moves or living arrangement disruptions in the past year, two years, etc.?

Life Area #2: Vocation/Day

Vocation is defined as "...meaningful employment in a real work setting of the client's choice or activities leading toward that goal." (From *Desired Outcomes for **Willie M.** Clients*) If vocational needs or goals are not yet applicable for a client due to the client's age or developmental level, indicate **N/A** (not applicable) in this life area. Be sure to include here any vocational needs which are being addressed by educational services.

- Is the client old enough to begin participation in pre-vocational or vocational activities?
- Is the client's choice to participate in vocational activities or to pursue further education? If the choice is to pursue further education, is the client capable?
- If the choice is vocational, is a comprehensive vocational assessment in order? Is an interest inventory in order?
- Does the client need to focus on pre-vocational skills?
- Does the client need to focus on job seeking skills?
- Does the client need to focus on job keeping skills?
- What kind of job or vocational activity is realistic for this child to be able to do as an adult?

Life Area # 3: Educational

The client attends and participates in educational services appropriate to his or her needs. (From *Desired Outcomes for **Willie M.** Clients*)

- At what grade level is the child reading? Is there a need to raise this grade level? At what grade level is the client in math?
- What is the child's learning style? Does the child have visual processing difficulties? Auditory processing difficulties? Does the client need to strengthen compensatory skills?
- What specifically appears to trigger disruptive school behavior? Is there a need to improve concentration? Is there a need to feel more accepted by teachers or students?
- Does the child need to have a reason to attend school? What specifically appears to be the source of lack of school attendance? Is it boredom? Is the client embarrassed by lack of skills?

- Does the child have sports/music or other special interests that need to be built on?

Life Area #4: Medical/Health/Psychiatric

The client will, to the extent that he is able, maintain a state of health sufficient for participation in normal, productive and rewarding activities. (From *Desired Outcomes for **Willie M.** Clients*)

- When was the client's last complete physical and what were the problem areas?
- Has there been any follow-up of these problem areas? If not, why?
- What medications are/have been prescribed? What are their side effects, dosages, etc.?
- Have there been any medications that did not work? What were the results, problems, etc.?
- What are the family's medical highlights? Are those related to or had an impact on the child's current health status?
- Are there any "rule-out" diagnosis? If so, when will they be ruled out?
- Does the child need to take more responsibility for proper self care?
- Does the child need to understand her physical, emotional, or mental limitations?
- What does the child need to be in good health?
- Is the child having problems performing at home, school, work, or play which could be health related? Are there medical problems (hearing, vision, gross/fine motion skills, auditory/visual processing, indication of neurological deficits, etc.)?

Life Area # 5: Behavioral/Therapeutic

The client develops the social competence and coping skills needed to reduce or ameliorate assaultive and aggressive behaviors. (From *Desired Outcomes for **Willie M.** Clients*)

- What type of positive behavior(s) are being exhibited?
- What types of negative behavior(s) are being exhibited?
- In what settings do the negative behavior(s) most frequently occur? Are there settings in which negative behavior(s) do not occur?
- What precipitates negative behavior(s)?
- What external methods/interventions are used successfully to control negative behavior(s)?
- Does he have internal control of behavior?
- Is the behavior(s) to gain attention?
- What emotional/trauma issues do you think could be driving the behavior(s)?
- Is negative behavior(s) creating a situation of danger to self or others?

- If running away, where is he or she running?
- If you could change one behavior, what would it be?

Life Area # 6: Support Network/Family/Social

The client has at least one person who is also an advocate, friend and confidant who maintains a long-term relationship with the child, fostering trust, self-esteem and social competence. (From *Desired Outcomes for **Willie M.** Clients*)

- Who is in the child's/family's immediate world?
- Who is in the child's/family's extended world?
- How does the child/family view these people?
- Based on the child's/family's/community's view of these people, are they supports or stresses?
- What characteristics or behaviors of the child are considered positive or negative, by and in the family, by and in the child's community, by and in mainstream society?
- Which characteristics or behaviors span consistently across environments?
- Where are there agreements from child, family, school, other agency and mental health professionals in areas of positive and negative characteristics or behaviors?
- Which one negative characteristic or behavior needs to be addressed first?
- How can the positives be used to assist with strategies to address the client's objectives?
- Does the child need a specific kind of attention from his or her family, and what supports are needed for the family to be able to provide this?
- Does the child/family seek and use support from their faith and/or church community? How important is this for this child/family?
- Does the family observe routines and rituals which support and enhance positive family connections?

Life Area # 7: Leisure/Recreation

Those pleasurable activities in which the client engages which teach positive ways to interact with others, structure time, relieve stress and expend energy.

- Does the client have specific interests or hobbies?
- Is the client engaged in structured leisure activities in the natural/home community, with his family, friends or paid staff?
- Is the client engaged in structured learning activities which teach/reinforce social skills?

- Is the client interested in sports?
- Can the client initiate appropriate leisure activities when given choices, free time, etc.?
- Can he initiate appropriate social activities with family, friends and peers?
- Is the client offered the opportunities to plan and fund recreational activities such as weekend trips, mini-vacations, organized contests/competitions, etc.?

Life Area # 8: Legal Services

The client learns to act appropriately within the legal system and engages in behaviors designed to alleviate the circumstances which brought about the law enforcement and/or court interventions in the client's life. For those clients involved in the legal system, planning in this area should include their need for client advocacy.

- Does the client have an advocate (GAL, significant other, court counselor)?
- Does the client have a plan stating goals or strategies to relieve probation? Is the child interested in getting off probation?
- Does the client have the appropriate legal services (includes attorney, court counselor, probation officer, advocate)?
- Has appropriate guardian been identified for client?
- Is the child at risk for further legal involvement which could result in commitment to training school or incarceration?

Life Area # 9: Crisis Services

Identify and plan for possible medical, psychiatric, behavioral crises or emergencies that may arise. Outline strategies as well as back up plans for dealing with them. This is a crucial and required component of the plan for every **Willie M.** client.

- How often does this child and family have a crisis?
- What is the anticipated behavior/event/trigger for a crisis?
- What effect does this crisis have on the community?
- Can you implement the crisis plan once written?
- Is there a critical event or behavior that may pose a threat to the community?
- How can you avoid a crisis from occurring?

Life Area # 10: Transitional

These are activities which will enhance the client's potential for successful movement from one service setting to another. In addition, this Life Area should also include those activities which will help the child achieve to his potential for independent living and/or participation in adult services. This is a required component of the plan for every client age 16 or older as well as younger, if appropriate.

- What are the reasonable expected life problems this client will encounter as an adult?
- What does the client need to be able to do in order to be as successful and independent as possible?
- Can this client live independently as an adult? If not, what supports will be needed?
- What skills does the client need in order to access the appropriate living arrangements?
- What skills need to be developed in order for the client to access appropriate leisure activities in the community as an adult?
- Did you consider transition issues in all of the other dimensions?

Life Area # 11: Specialized Services

These are interventions not dealt with elsewhere in the T/HP and may include Speech Therapy, Occupational Therapy, Physical Therapy, etc.

Life Area # 12: Assistive Technology

These are devices which may assist the client in adapting to a daily life which is as productive as possible. Examples are devices which allow a deaf person to use the telephone, computers constructed for the blind, etc.

Life Area # 13: Other

If there are other life areas which need to be addressed for this client, you may add it.

2. Individual's Strengths/Preferences

Enter **strengths/preferences** to be enhanced and supported and from which needs will be determined.

Strengths are those characteristics within the client and the client's environment which will both assist in achieving goals and in resisting factors which may put at risk the client's ability to lead the most productive life of which he is capable.

Preferences are the client's desired involvement with family, residence, work, educational opportunities, friends, leisure activities, and the service personnel with whom he wants to work. How much these preferences are incorporated into the Plan depend on the individual's age and mental, physical and social abilities.

Using individual strengths and needs as the basis for planning services for children and their families is a way of thinking that increases collaboration with clients and drives the development of an expanded array of accessible services. The guiding principle behind the strengths and needs-based approach is that **each service should be designed to meet a specific strength.** An important advantage of the strengths and needs-based approach is that it can be understood by children and their families.

Rules of thumb in identifying strengths include the following:

- Every child has strengths.
- Children and families feel more capable when their strengths are appreciated--this is a powerful intervention by itself.
- Services based on strengths are more effective than those driven by deficits.
- Strengths become evident when we consider the many skills that are required to survive impoverished environments.

3. Individual's Needs

Enter and prioritize **needs** to be addressed in order to achieve desired outcomes.

Needs are those issues which will either help the client achieve his desired outcomes or those which will reduce risks which might stand in the way of achieving identified goals. They are derived from an understanding of the client's strengths and risk factors (current or potential problem areas).

Over time, we have become less able to see children's needs because of the lack of services in our communities. Our view of children's needs has often been narrowed to fit the services we know are available. Seeing children's needs requires careful observation and listening to the child and other team members.

Some guidelines for identifying needs include being specific and not disguising services as needs. (For example, "Needs tutoring" is not a need; tutoring is a service. The child actually needs to improve reading skills.)

4. Individual's Desired Outcomes

List the Desired Outcomes which this Plan is intended to address. **Desired Outcomes** here mean positive changes in the life of the client intended to help him/her achieve the most productive adult life possible. Outcomes combine the concepts of goals, short term goals and objectives. Thus, desired outcomes can refer to long-term results or to more specific immediate steps to be taken. They are to be behaviorally stated, measurable, and time specific and can be short or long term in nature.

Outcomes are *client focused* - that is, they refer to changes, or steps taken by the client.

Outcome Status Code - Enter a code for each Desired Outcome.

N=New:	When first documenting a desired outcome.
R=Revised:	When changing an existing desired outcome.
O=Ongoing:	When not changing an existing desired outcome.
A=Achieved:	When showing a desired outcome as accomplished.
D=Discontinued:	When dropping a desired outcome without achieving it.

Projected date of:

Implementation - Enter the date strategies or behaviors aimed at achieving each desired outcome will begin.

Accomplishment

Planned - Enter the date planned to achieve the desired outcome.

Actual - Enter the date when the desired outcome is, in fact, achieved.

5. Supports Needed/Strategies (Dates Where Appropriate)

These are team or staff focused. List the actions **team members** (staff and other important adults) will take in order to assist the child to achieve desired outcomes. Once the child's needs have been identified and prioritized, each need should be matched to a service which is building upon strengths. This is a step-by-step process of tailoring each service to meet each need and accompanying desired outcome. The services should be generated based on the need without being limited by existing services. Access to community-based services is important, however, as services must be within reach, compatible with the family's ethnic and sociocultural background, thoroughly explained to the child and guardian, and timely.

Responsible Person - Enter names of the people who are accountable for implementing the strategies or supports.

Case Management / Service Monitoring Page

The **Willie M.** Case Manager is the person designated by the **Willie M.** habilitation planning system to have primary responsibility for coordinating the planning and monitoring service delivery to each assigned client.

Planned monitoring of services requires that workers develop the self-confidence to hold other people (from community supports and a variety of agencies) accountable for services. Once a plan has been developed, its effectiveness in meeting the child's needs must be regularly assessed (at least monthly). The services for the child must be adjusted as needed by adding unanticipated services/deleting services or providing services in different ways. The frequency and duration of services provided will depend upon the individual needs of the child and family as well as how effective the services are at assisting the client to achieve his desired outcomes.

1. Type, Frequency/Contact Schedule

For each "**Type**" of contact listed, describe how often (i.e. daily, weekly, bi-weekly, monthly) and how or in what manner the Case Manager will monitor the client's progress (i.e. observation, meetings, correspondence, documentation review).

Face to Face Include planned face-to-face contacts here.

A. Individual:
The Case Manager must meet face-to-face with the client at least monthly.

B. Guardian/Family:
The Case Manager must meet/contact guardian and family regularly enough to assess their satisfaction with and participation in planning and implementing services.

C. Provider(s):
The Case Manager must maintain contact with providers on a schedule which allows appropriate monitoring and coordinating with the service providers.

D. Collateral's:
Include planned contacts not documented above.

E. Review of Remittance Status Report:
Not required for **Willie M.** clients.

F. Review of Case Management Indicator on Medicaid Card:
Not required for **Willie M.** clients.

When monitoring reveals a change in the client's needs, situation, etc., the Case Manager must consider changing the Plan (with the consent of the client, responsible parties, and others involved with the client's care and service delivery) and initiate ***Plan Updates.***

2. Other/Comments

If this is a first plan, and it is incomplete, indicate the reason here and describe the steps to be taken to complete the plan. The Case Manager may make other comments here as s/he deems appropriate.

3. Name / Signature

The signatures indicate that the signers have reviewed and agree to the PLAN.

- **Plans must be signed by the client (if possible according to age and ability), the parent(s)/ guardian(s) representative, the case manager, and the school representative**

- Other people who will be actively involved in planning and implementing services should also sign the Plan.

What if someone refuses to sign the PLAN?

Every effort should be made during the meeting to work through any disagreements. Case Managers should lead the team through a problem solving process to understand the underlying issues and reasons for the disagreement. The team will need to make a decision on what course of action to take and determine how to address the presented need and what services to provide. If the parent/guardian still disagrees, he or she should be given the booklet on how disagreements are resolved, and the Case Manager should work with the parent/ legal guardian to resolve the disagreement.

Treatment/Habilitation Plan Update

The T/HP must always be reviewed on the annual review date, regardless of when the plan was last completed or updated. If the plan was just recently changed or updated, you can complete the Update Signature/Comment page to show that you have done the annual review. If you determine that only one or two areas of the plan requires changes and these changes will not affect the rest of the plan, then you may be able to complete a ***T/HP Update***.

Specific procedures for ***T/HP Updates***:

- Identify one or two areas of the plan which require changes but will not affect the rest of the plan as a whole.

- The case manager discusses this with the appropriate people and coordinates a meeting with the client, family/guardian, treatment/ habilitation team members who are or will become providers of the services as well as the LEA/DPI representative(s). (***Note:*** Always confirm that proper releases are completed and on file, especially if new providers/contractors are being added.)

- Complete the ***T/HP Plan Update*** for up to two Life Areas. Include all previous information that is still accurate.

- Use the Life Area page alone as a continuation page for a particular life area if there is not enough room to do it on the original plan **or**

- Use both pages of the Update to describe changes in a particular Life Area:

  - When minor changes need to occur in the plan in no more than two Life Areas **and**

  - When these changes will not affect other areas of the plan (e.g., the addition of group therapy in the *Behavioral/Therapeutic Life* Area, or a change in the *Crisis Services*, etc.) **or**

- Obtain signatures of client, parent/guardian and case manager

- Send two copies of the ***T/HP Plan Update*** to the **Willie M.** Section office in Raleigh (only one copy if the RSM is located in the Section office).

NOTE: Completing the T/HP Plan Update with signatures serves as "prior notice" as required in the NC Administrative Code. *(Formal notice of any proposed changes in services for a client must be provided to the parent, guardian and/or legal advocate, as required by North Carolina Administrative Code, Section .7000, Rule .7016(a). Procedures governing the content and distribution of the Prior Notice are outlined in* ***Willie M.*** *Administrative Letter 98-01.)*

Before submitting a ***T/HP Update***, case managers should meet with the client, family, guardian, and at a minimum, those treatment/habilitation team members and/or providers who are directly involved or affected by the change. If the client is in school, LEA/DPI representative(s) should be invited to team meetings, even if the specific change being planned may be minor and does not affect any of the services they provide. Remember, ***Updates*** are tied to the ***T/HP*** and therefore are in effect only until the whole plan is due to be reviewed and updated.

Life Area Page

Fill out this page in the same way as described for the T/HP Life Area Page.

Signature/Comment Page

1. Comments

Describe any changes to services and explain reason(s) for the change. Use this area to explain any missing required signatures.

2. Individual's Comments

The client may make comments here.

3. Family/Guardian Comments

The family and/or guardian may make comments here.

4. Signatures

The signatures mean that each person was involved in developing the plan and agrees with the services and supports to be provided.

CAP-MR/DD (Community Alternatives Program For Persons with Mental Retardation and Other Developmental Disabilities)

If a **Willie M.** client is also found appropriate for CAP-MR/DD services, you may use the T/HP for the **Willie M.** program or the T/HP for the CAP-MR/DD program to document plans. There are some differences in the two plans, but most is the same.

The **Willie M.** program uses some pages not used by the CAP program such as the Assessments Page and Life Chart Page. Conversely, the CAP-MR/DD program uses a Cost Summary Page not used in the **Willie M.** program. All of these pages are required for a **Willie M.** client who is also a CAP-MR/DD client. Some differences are described below.

Face Sheet

4. Plan approved By/Plan Approval Date

If the client is also CAP-MR/DD funded, the plan is submitted to that Section for approval. A separate effective date is issued by CAP-MR/DD, but this does not affect the **Willie M.** planning process or the next planning date.

19. CAP-MR/DD Population

If the client is CAP/MR-DD, check whether the client is **at risk** for being institutionalized or is currently residing in an ICF/MR facility (refers to an Intermediate Care Facility for the mentally retarded). If the client is discharged from an ICF/MR facility directly into CAP, the "ICF/MR" block will be checked on the Initial Plan of Care and all subsequent Continued Need Review plans. One of the two choices **must** be checked since all CAP/MR-DD clients must be considered **at risk** by virtue of either of these circumstances.

ASSESSMENT AND LIFE CHART PAGES

These pages are required for **Willie M.** and optional for CAP-MR/DD and **Thomas S.** If you are submitting this plan for CAP-MR/DD, either do not send these pages to them or be sure *not* to include IQ scores in the information on the Assessments page when submitting the plan for CAP-MR/DD approval.

APPENDIX A NC ADMINISTRATIVE RULES SECTION .7000 - SERVICES FOR ELIGIBLE ASSAULTIVE AND VIOLENT CHILDREN AND ADOLESCENTS

SECTION .7000 - SERVICES FOR ELIGIBLE ASSAULTIVE AND VIOLENT CHILDREN AND ADOLESCENTS

.7001 SCOPE

(a) The rules in this Section implement G.S. 122C-112(a)(14) and 122C-194 through 122C-200 by establishing requirements for:
  (1) designating Eligible Assaultive and Violent Children (EAVC);
  (2) ensuring needs assessment, planning and provision of services to EAVC clients; and
  (3) administrative review of decisions related to EAVC services or eligibility

(b) These Rules shall govern all disputes related to EAVC services and eligibility unless those disputes are governed by G.S. 115C-116.

(c) Each EAVC client shall be provided services that include:
  (1) habilitation, including medical treatment, education, training and care, suited to his essential needs, which affords him a reasonable chance to acquire and maintain those life skills that enable him to cope as effectively as his own capabilities permit with the demands of his own person and of his environment and to raise the level of his physical, mental and social efficiency. Such habilitation shall create a reasonable expectation of progress toward the goal of independent community living.
  (2) the least restrictive, i.e., most normal, living conditions appropriate for that person. Among the factors to be considered in determining the least restrictive living conditions appropriate for the individual are the need to minimize institutionalization and the need to minimize the possibility of harm to the individual and society.
  (3) goals, as appropriate to the individual, that enable the client to move from:
    (A) Living and programming segregated from the community to living and programming integrated with the community;
    (B) More structured living to less structured living;
    (C) Group residences to individual residences; and
    (D) Dependent living to independent living.
  (4) such placements and services as are actually needed as determined by a Treatment/Habilitation Plan rather than such placements and services as are currently available. If placements and services actually needed are not available, they shall be developed and implemented within a reasonable period. Prior to development and implementation of needed placements and services, the person shall receive placement and services which meet as nearly as possible the person's actual needs.

History Note: Authority G.S. 122C-3, 122C-112, 122C-194, 122C-195;122C-196;122C-197; 122C-198, 122C-199, 122C-200;
Eff. March 1, 1997.

.7002 DEFINITIONS

(a) This Rule contains definitions that apply to all of the rules in this Section. Definitions contained in G.S. 122C-3 shall also apply.

(b) Unless otherwise indicated, the following terms shall have the meanings specified:
  (1) “Advocate or Representative” means an attorney or guardian ad litem pursuant to G.S. 7A for an EAVC applicant or client. In the event that an EAVC applicant or client has a representative other than an attorney retained by the client or parent/guardian or GAL appointed under G.S. 7A, the Department or Division shall retain the right to challenge whether a representative is in fact acting on behalf of the child and at the child's request.
  (2) “Appropriate Services” means services which include a good faith and professionally competent effort to enable the child to overcome or cope with the problems that led to eligibility and to prepare the child for the reasonably expected life and problems to be encountered in adulthood. The provision of appropriate services is judged against the essential needs of the individual, which are based on the capabilities and potential of the individual. The eligible client is not guaranteed a “cure” or a “positive outcome,” but rather a good faith effort to accomplish the goals set forth herein.
  (3) “Contract agency” means an agency or entity under contract with the Division, acting in the role of an

area program for purposes of serving EAVC in a particular geographic area.

(4) "Division" means the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS).

(5) "Director" means the Director of the Division of DMH/DD/SAS.

(6) "EAVC applicant or Willie M. nominee" means any child under the age of 18 who has applied for or been nominated for determination of eligibility as a Willie M. class member or an EAVC client.

(7) "Eligible assaultive and violent child (EAVC)" means a child under the age of 18 who has been determined by the Department of Human Resources to meet the eligibility criteria as defined in these Rules and is eligible to receive the services needed.

(8) "Essential needs" means behaviors, areas of functioning or critical problems which must be addressed in order for the child to overcome or cope with the problems that led to EAVC eligibility, to prepare for adulthood and to acquire and maintain life skills consistent with the individual's potential and capabilities.

(9) "Lead agency" means the Division at the State level and the area mental health, developmental disabilities and substance abuse program or contract agency at the local level.

(10) "Legally responsible person" means the term as defined in G.S. 122C-3(20).

(11) "Outcome domain areas" means areas, as indicated for each EAVC client, within which a client's essential needs shall be defined. The areas shall include social, behavior, education, vocation, housing/residential, and health (including mental health).

(12) "Treatment/habilitation plan (T/HP)" means a written plan which is developed by the group of individuals (the team) knowledgeable about and involved with addressing the child's essential needs. The plan contains a written statement of the child's essential needs in areas or domains, of life (as defined in this Section), and the supports and interventions which are required in order to address the child's essential needs (as defined in this Section). Mandatory members of the T/HP team include the child, parent or guardian, case manager and local school system representative. Clinical input concerning the child's essential needs for use in developing, implementing and reviewing the T/HP shall be provided to the team by clinicians with expertise and experience related to serving children with emotional, mental, or neurological handicapping condition accompanied by behavior characterized as assaultive or violent.

(13) "Willie M. Class Member" means a child under the age of 18 who has been or is determined by the Department of Human Resources to meet the criteria for inclusion as a member of the plaintiff class in the Willie M., et al. v. James B. Hunt, Jr., et al. lawsuit (United States District Court for the Western District of North Carolina C-C79CV294 - MU). All Willie M. class members, otherwise eligible for services, are Eligible Assaultive and Violent Children, according to the rules herein.

(14) "Youth Behavioral Services Client (YBSC)" means, for the purposes of these Rules, a Willie M. class member and an EAVC.

History Note: Authority G.S. 122C-3; 122C-112;
Eff. February 1, 1997;
Transferred and Recodified from 10 NCA C 18W. 0202 Eff. February 7, 1997.

.7003 GENERAL PROVISIONS

(a) The Director shall have lead responsibility in carrying out the implementation of these Rules and services provided pursuant to these Rules.

(b) Designation as a YBSC minor is voluntary and shall occur only with the consent of the legally responsible person.

(c) All certified members of the Willie M. class, eligible for services, shall be designated Youth Behavioral Services Clients unless consent is withdrawn by the legally responsible person.

(d) If a legally responsible person or an emancipated minor refuses services after the minor has been determined eligible as a YBSC, the area program or contract agency shall make periodic contacts with the legally responsible person or the emancipated minor to encourage consent for receipt of services.

(e) The area program or contract agency shall maintain a record of its efforts to obtain consent. Such efforts shall include, but not be limited to phone calls, registered letters, home visits, contact with the family through individuals or agencies having a relationship with the minor and legally responsible person.

(f) Where services are refused, the agencies shall report such refusal to the local Department of Social Services if it constitutes neglect of the minor's medical needs.
(g) Refusal of consent for eligibility determination or for services shall cause an applicant or client to be placed in "inactive" status until such time as consent is obtained, or until the child is 18 years of age.
(h) The legally responsible person and the area program or contract agency shall notify the Division of the occurrence of any circumstance which effects the eligibility of a YBSC or applicant to receive services. The Division shall be notified if:
    (1) the legally responsible person or emancipated minor withdraws consent for determination of eligibility or refuses services;
    (2) the client is admitted to an adult corrections facility operated by the North Carolina Department of Corrections;
    (3) the legally responsible person's State of residence changes; or
    (4) the client dies.
(i) A child under the age of 18 who is an applicant for eligibility as a YBSC or who has been determined by the Department of Human Resources to meet the eligibility criteria for being a Willie M. class member or a YBSC is ineligible for services if any one of the following circumstances exists:
    (1) The child's legally responsible person is not a legal resident of North Carolina; or
    (2) The child has been confined under a criminal sentence in a facility operated by the North Carolina Department of Corrections.

If either of the circumstances in this Paragraph changes before the child is 18 years of age, the child shall again be eligible for services until age 18, as set forth in these Rules.

(j) The death of a Willie M. class member or YBSC ends the minor's eligibility for services.
(k) Fees for services provided pursuant to these Rules, with the exception of education services, shall be charged and collected consistent with the provisions of G.S. 122C-146.

History Note: Authority G.S. 122C-112; 122C-146;
Eff. March 1, 1997.

.7004 ELIGIBILITY CRITERIA

In order to be designated a Youth Behavioral Services Client, a minor shall have an application filed in accordance with these Rules and:

(1) suffer from emotional, mental or neurological handicaps as set forth in Rule .7005 of this Section;
(2) the minor's handicap shall be accompanied by behavior that is characterized as violent or assaultive, as defined in Rule .7006 of this Section;
(3) be or have been involuntarily institutionalized or otherwise placed in residential programs, including:
    (a) being mentally ill as defined by G.S. 122C-3(21) and admitted for evaluation or treatment to a treatment facility under G.S. 122C, Article 5 or being presented for admission and denied due to their behaviors or handicapping conditions:
    (b) referral to an area mental health, developmental disability and substance abuse program pursuant to G.S. 7A-647(3) for whom residential treatment or placement is recommended;
    (c) placement in a residential program as a condition of probation pursuant to G.S. 7A-649(8);
    (d) being ordered to a professional residential treatment program pursuant to G.S. 7A-649(6); or
    (e) commitment to the Division of Youth Services pursuant to G.S. 7A-649(10); and
(4) is a minor for whom the State has not provided appropriate treatment and educational programs as defined in Rule .7007 of this Section.

History Note: Authority G.S. 7A-647(3); 7A-649(l), (6), (10); 122C-3, 122C-112; 122C, Article 5;
Eff. February 1, 1997;
Transferred and Recodified from 10 NCAC 18W.0204 Eff. February 7, 1997.

.7005 EMOTIONAL, MENTAL OR NEUROLOGICAL HANDICAP DEFINED

To meet the requirement of suffering from emotional, mental or neurological handicaps, a minor shall:

(1) have one or more conditions so diagnosed according to International Classification of Diseases-9, American Association of Mental Deficiency, or Diagnostic and Statistical Manual of Mental Disorders-IV

systems of categorization (exceptions to this criterion shall include those disorders in the DSM-IV, published by the American Psychiatric Association, 1400 K Street, NW, Washington, DC 20005 at a cost of thirty nine dollars and ninety five cents ($39.95) for the soft cover edition and fifty four dollars and ninety five cents ($54.95) for the hard cover edition. Incorporation by reference of DSM-IV includes subsequent editions and amendments, to which no logical or reasonable connection can be made between that disorder and accompanying assaultive or violent behavior; e.g., nicotine-related disorders.

In addition, V codes, with no accompanying Axis I-III diagnoses, do not constitute an emotional, mental or neurological handicap. Such exceptions would apply only when there is no other emotional, mental or neurological handicap); or

(2) meet the criteria for handicapping conditions contained in G.S. 115C-108 and 115C-109; or

(3) meet the statutory definition of mental illness for a minor in G.S. 122C-3.

History Note: Authority G.S. 122C-3; 122C-112; 122C-194;
Eff. March 1, 1997;
Transferred and Recodified from 10 NCAC 18W.0205 Eff. February 7, 1997.

.7006 VIOLENT OR ASSAULTIVE BEHAVIOR DEFINED

(a) To meet the criterion of violent or assaultive behavior, there shall be evidence in the minor's recent history (within the 12 months prior to the application or request for re-review of eligibility) or current functioning of one or more of the following:
   (1) physically attacks, with or without weapons against other persons or animals, or physical attacks resulting in property damage;
   (2) physically self-injurious behavior or serious suicidal attempts;
   (3) threatened attacks with a deadly weapon;
   (4) firesetting; or
   (5) predatory sexual behaviors.

(b) In addition, the behaviors shall meet one or more of the following tests:
   (1) the attack shall be sufficiently severe that substantial harm to persons did result or could result without intervention;
   (2) the behavior shall have occurred with sufficient frequency to be considered a pattern of response (more than three times over a period of six months);
   (3) the behavior is extreme or out of proportion to the provocation, if any, or is not an age-appropriate reaction;
   (4) the behavior was sufficiently disruptive to lead to extrusion from or refusal for admittance to school, job, recreational setting, or treatment program;
   (5) the behavior resulted in severe measures of control, e.g., seclusion, restraints, or chemical controls; or
   (6) the behavior resulted in incarceration or institutionalization with the restrictive environment then .controlling" the behavior.

History Note: Authority G.S. 122C-3; 122C-112,- 122C-194;
Eff. February 1, 1997;
Transferred and Recodified from I 0 NCA C 18W. 0206 Eff. February 7, 1997.

.7007 DETERMINATION THAT STATE HAS NOT PROVIDED APPROPRIATE TREATMENT

(a) To meet the criterion that the State has not provided appropriate treatment, the application shall show evidence of one or more of the following conditions, in addition to meeting the other criteria outlined in Rule .7004 of this Section:
   (1) The minor has a diagnosis and a prescribed need for treatment that has not been implemented; or the current treatment or education services are not based on assessments which reflect the child's essential needs.
   (2) The minor has an Individual Education Program that has not been implemented.
   (3) The current treatment or education program must use restrictive measures (e.g., seclusion, mechanical or chemical restraints) that would not be necessary with more staff, staff trained more specifically in relation to the minor's behavior, if the program offered more security, or if needed service supports

were available.

(4) Multiple residential treatment placements (more than three in a one- year period), which are disrupted due to the inability of the placement to provide supports or services which are sufficient or intensive enough to address the child's treatment needs.

(5) The current treatment plan could be implemented as effectively or more effectively in a less restrictive setting, if one existed and if an array of sufficient support services existed, which would still address the child and community's needs for safety. Examples of a "less restrictive setting," include:

(A) a setting that allows the minor more mobility, more exchange with peers, family or community outside of the treatment setting, and which still addresses the child and community's needs for safety;

(B) a smaller, more home-like setting or a more normalized environment; and

(C) the minor's own home.

(b) In addition to meeting at least one of five conditions listed in this Rule, there must be evidence that the child's treatment and education needs are not or could not be met through existing and readily available services and supports which the child can access, or to which the child is entitled from any source.

(c) If a child is denied eligibility for services based on the determination that needs can be met through existing services which are not currently being provided, the area program, contract agency or Division shall ensure the provision of such services.

(d) For minors who are determined ineligible due to a finding that the current services are appropriate to their needs, evidence of changes in services or in treatment needs which cannot be met through available services shall be submitted to the Division for a re-review of eligibility.

(e) In the case of known and identified future service needs which do not exist or are not available, a request for re-review of eligibility may be made up to 90 days prior to discharge from or change in the current services.

(f) The request for re-review of eligibility determination shall include information on the service needs of the applicant which cannot be met by the currently available services.

History Note: Authority G.S. 122C-3,122C-112;122C-194;
Eff. February 1, 1997;
Transferred and Recodified from IO NC4 C 18W. 0207 Eff. February 7, 1997.

.7008 APPLICATION FOR DESIGNATION AS YOUTH BEHAVIORAL SERVICES CLIENT

(a) Any individual may make application for a minor as a potential Youth Behavioral Services Client by submitting an application to either the area program or contract agency whose catchment area includes the minor's legal county of residence or to the Division.

(b) Area programs shall not discourage the application of any minor and staff shall assist in preparing the application.

(c) Within 30 days of receiving an application from another agency or individual which is incomplete, the area program or contract agency shall collect and forward to the Division information needed to complete the application process, as outlined by the Division.

(d) Consent from the legally responsible person shall accompany the application.

(e) If someone other than the legally responsible person makes application for eligibility, and the application is submitted without consent from the legally responsible person, the Division shall notify the appropriate area mental health program or contract agency to obtain the required consent in order to make an eligibility determination. A formal eligibility determination shall not be made without consent from the legally responsible person.

History Note: Authority G.S. 122C-3, 122C-112; 122C-194;
Eff. February 1, 1997;
Transferred and Recodified from IO NC4 C 18W. 0208 Eff. February 7, 1997.

.7009 DETERMINATION OF ELIGIBILITY

(a) The Director, or his designee, shall determine the eligibility of an applicant for designation as a Youth Behavioral Services Client, according to the scope and criteria outlined in the Rules .7001, .7004, .7005,

.7006, and .7007 of this Section.

(b) The Director, or his designee, shall develop application requirements for applicants, area programs and contract agencies, and other agencies which are consistent with the criteria outlined in the rules and are designed to facilitate the appropriate and timely identification of clients who meet Youth Behavioral Services Client eligibility criteria.

(c) The Director, or his designee, shall ensure that information submitted for eligibility determination is reviewed by individuals with expertise and experience related to serving children with emotional, mental or neurological handicapping conditions accompanied by behavior characterized as assaultive or violent.

(d) During the submission process, all information shall be reviewed by Division staff who may request clarification or additional documentation to complete the application package. The Division shall reimburse area programs or contract agencies for services required in order to collect needed information for application packages and, if necessary, for conducting evaluations the Division determines are needed in order to gather sufficient information to make an eligibility determination.

(e) Within 30 days of obtaining a complete application package, a notice of the decision in response to the application shall be issued by the Division to the legally responsible person for the applicant, to the area director, the area Youth Behavioral Services Coordinator, the appropriate school system, and the referring individual or agency. Changes in circumstances of the applicant or legally responsible person or a request to obtain or review additional information in support of the application may result in a delay in the 30-day timeline. The Division shall notify the legally responsible person of any extension in the timeline for review of the application and the reasons for the extension. Extensions of the 30-day timeline for such reasons do not constitute a failure by the Division to meet the requirements set forth in this Rule.

(f) A separate formal letter containing the Notice of Decision shall be sent to the legally responsible person of the minor notifying them of the decision.

History Note: Authority G.S. 122C-3, 122C-112,- 122C-194;
Eff. February 1, 1997;
Transferred and Recodified from IO NCA C 18W. 0209 Eff. February 7, 199 7.

.7010 RE-REVIEW OF ELIGIBILITY DECISIONS

(a) The Division shall retain the application package for each applicant determined to be not eligible until the applicant's eighteenth birthday, and shall re-review (reconsider) the decision upon request if there is reason to believe that the applicant's handicapping condition, behavior and service needs meet the criteria. A request for re-review shall by submitted to the Division by the legally responsible person or advocate, and shall be accompanied by any new information or information not previously submitted.

(b) If the legally responsible person or advocate, the referring agency or individual, or the area program or contract agency disagrees with the determination of eligibility decision, they may request, in writing, that the Division conduct an Administrative Re-review of the original application package and resultant decision. A request for re-review shall be submitted to the Division by the party making the request, and shall be accompanied by any new information or information not previously submitted, and with the consent of the legally responsible person if they are not initiating the re-review request. The request for an Administrative Re-review shall include a statement summarizing the basis for the request.

(c) If additional information is needed in order to conduct a re-review and is not provided with the re-review request, the Division shall request that information and notify the legally responsible person or advocate and involved area mental health or contract agency of the information request and the reason for any delay in the re-review process.

(d) The Division shall re-review the original application, reconsider the earlier decision, and issue another eligibility decision within 30 days of receipt of a complete Administrative Re-Review request. All parties notified of the original decision shall be notified of the re-review decision.

(e) If the minor, the legally responsible person or advocate disagrees with the decision from the Administrative Re-Review, either party may initiate a contested case hearing to resolve the dispute.

History Note: Authority G.S. 122C-3; 122C-112; 122C-194;
Eff. February 1, 1997;
Transferred and Recodified from 10 NCAC 18W.0210 Eff. February 7, 1997.

.7011 NEEDS ASSESSMENT

(a) Each Youth Behavioral Services Client shall receive assessments and evaluations that are necessary for a thorough and accurate understanding of the minor's essential needs in the desired outcome domain areas: social, behavior, education, vocation, housing/residential, and health (including mental health).

(b) Essential needs shall be identified without regard to service availability.

(c) Essential needs in each of the six outcome areas set forth in Paragraph (a) of this Rule shall be addressed and prioritized within each domain as to their relative importance in the minor's life at the particular time. To the extent that needs must be prioritized, such prioritization shall relate to the timing of addressing needs rather than whether they should be addressed at all.

(d) Factors in both assessing and determining needs shall include:

(1) the minor's capabilities and potential;

(2) the minor's need for stability in personal relationships and the ability of caregivers (family and staff) to provide that stability;

(3) major risks to the minor's health, safety and integration with the community; and

(4) the minor or community's need for safety.

History Note: Authority G. S. 122C-3, 122C-1 12, 122C-194;
Eff. March 1, 1997.

.7012 SERVICE PLANNING

(a) Each Youth Behavioral Services Client shall have an individualized treatment/habilitation plan (T/HP) developed within 30 days of notice of eligibility as a Youth Behavioral Services Client. If identified as eligible for Exceptional Children's education services, the child shall also have an Individual Education Plan (IEP).

(b) The legally responsible person and client shall participate in development of the habilitation plan, and the Division shall facilitate this participation.

(c) The habilitation plan shall address the client's essential needs and reflect the prioritization required as a result of timing and developmental progress.

(d) Goals, objectives and strategies shall address movement toward a transition into adulthood that is consistent with the client's capabilities and potential and the reasonably expected life and problems the client will encounter as an adult.

(e) The habilitation plan shall provide each client with the most normal, least restrictive living arrangements and conditions appropriate to individual needs.

(f) The habilitation plan shall address the client's need for safety for both self and others. The need for least restrictive environment and the need to minimize the possibility of harm to the client and to society are factors to be considered in determining the level of restriction for the client's treatment and education setting.

(g) The habilitation plan shall include:

(1) goals, or global end results and objectives, or intermediate results, to be accomplished in order to achieve the identified goal.

(2) strategies and individual assignments for implementation, facilitation, and responsibility for each strategy (e.g., minor, legally responsible person, agency representative, etc.).

(3) measures of progress to be used for strategies directed toward the long-term desired outcomes for the client.

(4) risks (e.g., behavioral regression, medical deterioration) that threaten success of the plan, and supports and services to anticipate and address such risks.

(5) strategies for addressing crises.

(h) The habilitation plan shall be reviewed and revised with participation of the legally responsible person and client, as needed, but at least annually, based on changes in the child, including progress or lack of progress, significant life events, deterioration, and criminal behavior.

(i) As early as needed, but no later than age 16, a new habilitation plan shall be developed that includes specific goals, objectives and strategies related to transition to adulthood.

History Note: Authority G.S. 122C-3, 122C-112; 122C-194;

Eff. February 1, 1997;
Transferred and Recodified from 10 NCAC 18W.0212 Eff. February 7, 1997.

.7013 PROVISION OF SERVICES

(a) Services, with sufficient intensity and continuity to meet essential needs, shall be provided immediately to the extent that they are available.
(b) Services shall be directly related to the goals and objectives identified in the habilitation plan.
(c) To the extent necessary for the individual client, appropriate resources (neighborhood, extended family, church and other community resources) shall be used to facilitate integration into the client's existing or anticipated adult community.
(d) If needed placements and services, other than residential, do not exist or are not available, they shall be developed and implemented within 30 days after the habilitation plan is developed unless a longer period is agreed upon by the legally responsible person and the area program or contract agency. The timetable for development and implementation of needed residential services shall be agreed upon by the legally responsible person and the area program or contract agency. The habilitation plan shall include the timelines by which appropriate services will be developed and provided.
(e) The area program or contract agency shall take the necessary steps to develop and implement the needed services and shall notify the Division and seek necessary assistance for developing needed services.
(f) The minor's T/HP shall include services and supports which will be provided in the interim, until appropriate services are available.
(g) In addition, the T/HP shall include timelines by which appropriate services will be developed and provided.
(h) Prior to development and implementation of needed services, a Youth Behavioral Services Client shall receive, in the interim, services which meet as nearly as possible all essential needs.
(i) Services for a Youth Behavioral Services Client may continue beyond the client's eighteenth birthday if the individual:
    (1) continues to be in need of such treatment and will benefit from continuing placement or involvement in services which the client is receiving treatment on his/her eighteenth birthday; and
    (2) voluntarily agrees to continue treatment in those services in a manner consistent with state law or is confined pursuant to applicable state law.

If the conditions in this Paragraph are met, services may continue beyond the client's eighteenth birthday for six months or until the end of the current fiscal year, whichever is longer. If, after turning eighteen and before the extension period has been exhausted, the client decides to terminate or ceases participation in services, the client's eligibility for continued services under these rules ends at that time.

(j) A determination of eligibility as a Youth Behavioral Services Client shall not preclude or prevent access to services to which the minor would otherwise be entitled.

History Note: Authority G.S. 122C-3, 122C-112; 122C-194;
Eff. February 1, 1997;
Transferred and Recodified from 10 NCA C 18W. 0213 Eff. February 7, 1997.

.7014 AREA PROGRAM REQUIREMENTS

(a) Area programs or contract agencies shall, directly or through contract agencies, provide services for Youth Behavioral Services Clients whose legal county of residence is located in their catchment area.
(b) Each area program or contract agency shall establish procedures for providing services to Youth Behavioral Services Clients, including designation of an area program Youth Behavioral Services Client Coordinator, submission of required information and reports to the Division, and information-gathering and preparation of needed evaluations for applications of potential Youth Behavioral Services Clients.
(c) Each area program or contract agency that has a Youth Behavioral Services Client shall establish and maintain accreditation for provision of services to Youth Behavioral Services Clients pursuant to 10 NCAC 14V .0600, Accreditation of Area Programs and Services, contained in Rules for Mental Health, Developmental Disabilities and Substance Abuse Facilities and Services, Division publication APSM 30-1.
(d) Each area program or contract agency shall comply with budgeting and fiscal requirements as established by law.
(e) Each area program or contract agency shall assist in the collection or development of information needed

to process applications for potential Youth Behavioral Services Clients.

(f) Each area program or contract agency shall develop individualized treatment/habilitation plans (T/HPs) for each eligible YBSC.

History Note: Authority G.S. 122C-3, 122C-112; 122C-194;
Eff. March 1, 1997.

.7015 DIVISION REQUIREMENTS

The Division shall:

(1) regularly monitor provision of services to individual Youth Behavioral Services Clients, including periodic sample reviews of the individual treatment/habilitation plans of Youth Behavioral Services Clients.

(2) monitor, at least on an annual basis, a sample of Youth Behavioral Services Clients and make determinations as to whether they are receiving needed services.

(3) address service deficiencies for individuals and groups of Youth Behavioral Services Clients and take steps necessary to meet the client's needs, as those deficiencies are identified through special as well as ongoing monitoring activities.

(4) ensure that there is a review of a sample of its determinations as to appropriate services for individual Youth Behavioral Services Clients and of a sample of its assessments of local systems of services conducted by an independent entity on at least a biannual basis.

(5) together with the Department of Public Instruction, monitor on an annual basis the provision of services by local programs, including area mental health programs, local school systems, and other local agencies or contract agencies which have responsibilities for services to Youth Behavioral Services' Clients.

(6) provide funding to area programs and contract agencies for Youth Behavioral Services Clients, for services, and for information-gathering by area programs or contract agencies as part of the application process for Youth Behavioral Services Clients, as made available from the General Assembly and through federal sources. These funds shall be expended according to applicable State laws. Funds appropriated by the General Assembly for Youth Behavioral Services Clients shall be expended only for programs serving Youth Behavioral Services Clients, including evaluations of applicants.

(7) reallocate these funds among services to Youth Behavioral Services Clients during the year as it deems advisable in order to use the funds efficiently in providing appropriate services to Youth Behavioral Services Clients.

(8) notwithstanding any other provision of law, if the Division determines that a local program is not providing appropriate services to Youth Behavioral Services Clients, the Division shall ensure the provision of these services through contracts with public or private agencies or by direct operation by the Division of such services.

History Note: Authority G.S. 122C-3, 122C-112, 122C-194;
Eff. March 1, 1997.

.7016 PRIOR NOTICE OF DECISION

(a) Notice of decision shall be given to a minor's legally responsible person and advocate whenever the Division, an area program or other service-providing agency initiates or proposes to change; or after request by the minor's legally responsible person or advocate refuses to initiate or change:
  (1) the eligibility status of a Youth Behavioral Services Client or applicant;
  (2) a client's needs assessment;
  (3) a client's T/HP; or
  (4) a client's services or placement.

(b) Timing: Notice of decision shall be provided within a reasonable time prior to the intended action, but not later than ten days prior to the effective date of the proposed action for eligible Youth Behavioral Services Clients. Notice of decision for an eligibility determination decision shall be provided when the decision is made by the Division. The minor's legally responsible person or advocate may appeal the eligibility decision from this point in time.

(c) Means of Notice: The notice of decision shall be in writing in language understandable to the general public, and provided in the native language or other mode of communication of the legally responsible

person or advocate unless it is clearly not feasible to do so. The area program, contract agency or Division shall document both that the notice has been sent to and efforts to ensure receipt by the legally responsible person or advocate.

(d) The characteristics of Youth Behavioral Services Clients may necessitate the prompt initiation or changes in services in response to unanticipated needs or behaviors or in order to ensure the ongoing safety of the clients or community. In these situations, the area program or contract agency shall take the steps necessary to ensure the safety of the client or community, including the initiation, change or cessation of services. The area program or contract agency shall then immediately provide notice to the legally responsible person or advocate of the actions taken and the reasons for the actions.

(e) Content: The notice of decision, at a minimum, shall state the name of the client or applicant, the action requested, the intended action or refusal to act, and the effective date of the proposed action or refusal to act. In addition, the notice shall:

(1) explain why the agency proposes to act or refuses to act;

(2) describe the evaluation or assessment procedures, tests, records or reports that the agency uses as a basis for the proposed action or refusal;

(3) describe any other factors relevant to the agency's decision;

(4) describe any options that agency considered, and why those options were rejected, if applicable; and

(5) provide a full explanation of the client's procedural safeguards with respect to the agency's decision, including:

(A) the right to voluntary mediation, how to request it, and to whom to make the request;

(B) the right to an impartial administrative review under contested case hearing procedures, the grounds specified in G.S. 122C-195 for obtaining administrative review of proposed decisions, the procedure for initiating administrative review, and the time limits in which to initiate administrative review;

(C) the right to review the decision and the opportunity to examine records related to the decision;

(D) the right to seek an independent evaluation;

(E) the right to be represented by counsel; and

(F) in the case of a determination of noneligibility, the right to submit additional information and request an administrative re-review of eligibility before proceeding with a contested case hearing.

History Note: Authority G.S. 122C-3; 122C-112,- 122C-194;
Eff. February 1, 1997;
Transferred and Recodified from 10 NCAC 18W.0216 Eff. February 7, 1997.

.7017 MEDIATION

(a) If after prior notice of the proposed change in the needs assessment, plan or services for a Youth Behavioral Services Client, there is a dispute over the specific action or the rationale for the action included in the prior notice, the Director of the area program, contract agency or Division shall implement, or the legally responsible person or advocate for a Youth Behavioral Services Client may request, a facilitation of resolution of the dispute.

(b) When a facilitation of resolution process has been agreed to by the legally responsible person or advocate, the Director of the area program or contract agency shall notify the Division and shall meet, or designate an assistant or associate to meet with the legally responsible person or advocate, other involved local agency representatives and regional staff for the Division assigned responsibility for Youth Behavioral Services Clients to facilitate resolution of the dispute prior to formal mediation. Facilitation of resolution of the dispute shall occur within ten days of the initiation of the facilitation process by either the involved local agency or by the legally responsible person or advocate.

(c) If a consensual agreement is not reached through the facilitation of resolution process within ten days after the initiation of the facilitation of resolution process, or if the legally responsible person or advocate does not wish to participate in a facilitation of resolution process, the legally responsible person or advocate may request voluntary third party mediation as described in G.S. 122C-197. Such a request shall be made, formally or informally, to the director of the involved area program, to the director of the agency proposing the decision, or to the designee of either agency as identified in the prior notice or notice.

(d) Upon receiving a request for voluntary third party mediation, the director, or designee, of the agency

proposing the decision shall schedule and conduct, within ten working days of the initiation of the mediation process, a mediation with the individuals designated in G.S. 122C-197. The meeting shall be informal and nonadversar-ial. No witnesses shall be placed under oath or cross-examined.

(e) Requests for mediation of disputes regarding eligibility decisions shall be made directly to the Division.

History Note: Authority G.S. 122C-3,- 122C-112; 122C-194;
Eff. February 1, 1997;
Transferred and Recodified from I 0 NCA C 18W. 021 7 Eff. February 7, 1997.

.7018 CONTESTED CASE HEARINGS

(a) The legally responsible person or advocate may obtain review of proposed decisions on the grounds and in the manner specified in G.S. 122C-195.

(b) Any agency served with a petition seeking such review shall advise the Division and the appropriate area authority immediately and furnish each with a copy of the petition if the Division or the area authority have not been named as parties.

(c) A local or state agency may obtain review as provided by these rules and applicable state laws if a legally responsible person or advocate refuses to consent to the evaluation of the minor or to the provision of services for a Youth Behavioral Services Client if there is a reason to believe that such refusal to consent constitutes medical neglect of the minor's treatment needs, person or advocate, area program/contract agency director, and Division Director.

(d) A decision made pursuant to a contested case hearing shall be in writing and shall be provided to the legally responsible person or advocate, area program/contract agency director, and Division Director.

(e) The local or state agency shall inform the legally responsible person or advocate of the right to representation by counsel and of any free or low-cost legal or other relevant services available in the area.

(f) During the pendency of any administrative or judicial proceeding regarding a dispute governed by these rules, unless the local or state agency and the legally responsible person agree otherwise, the child involved in the dispute must remain in present services.

History Note: Authority G.S. 122C-3; 122C-112; 122C-194;
Eff. March 1, 1997.

.7019 ADMINISTRATIVE REVIEW BY REVIEW OFFICER

(a) Appeal to Review Officer: Any party to an administrative review proceeding may appeal the decision of the administrative law judge to an impartial Review Officer as specified in G.S. 122C-199. Notice of the appeal shall be directed to the Division Director.

(b) Review Officer Pool: The Director shall establish a pool of individuals approved to serve as Review Officers for appeals of Youth Behavioral Services Client decisions. The list of approved Review Officers in the pool and their qualifications shall be made available on request. Review Officers shall meet the following qualifications:

(1) Review Officers shall be professionals in the fields of education, mental health, social services, law, or medicine, or shall be qualified by relevant education and experience in the area of services for children who have emotional, mental or neurological handicaps and accompanying violent and assaultive behavior, and shall have background in or knowledge about the eligibility criteria for Youth Behavioral Services Clients.

(2) Review Officers shall have experience in, or receive training in, the conduct of administrative hearings.

(3) Review Officers may not be employees or officials of either the Department of Human Resources, the Department of Public Instruction, the Office of the Governor, or of any agency involved in the care of the minor who is the subject of the case. A person is not disqualified as an employee merely because he or she is paid by the agency to serve as a Review Officer.

(4) Review Officers shall disqualify themselves in cases of personal or professional conflicts of interest or in cases where substantial portions of their income are derived through contractual arrangements with an involved agency.

(c) Conduct of Review:

(1) Upon selection of a Review Officer, the agency shall forward the hearing record to the Review Officer.

(2) The Review Officer shall review the entire hearing record and determine whether:
   (A) the procedures at the contested case hearing were consistent with the requirements of the Administrative Procedures Act;
   (B) to conduct an additional hearing in accordance with the procedures set forth in this Paragraph; and
   (C) to afford the parties oral or written argument.

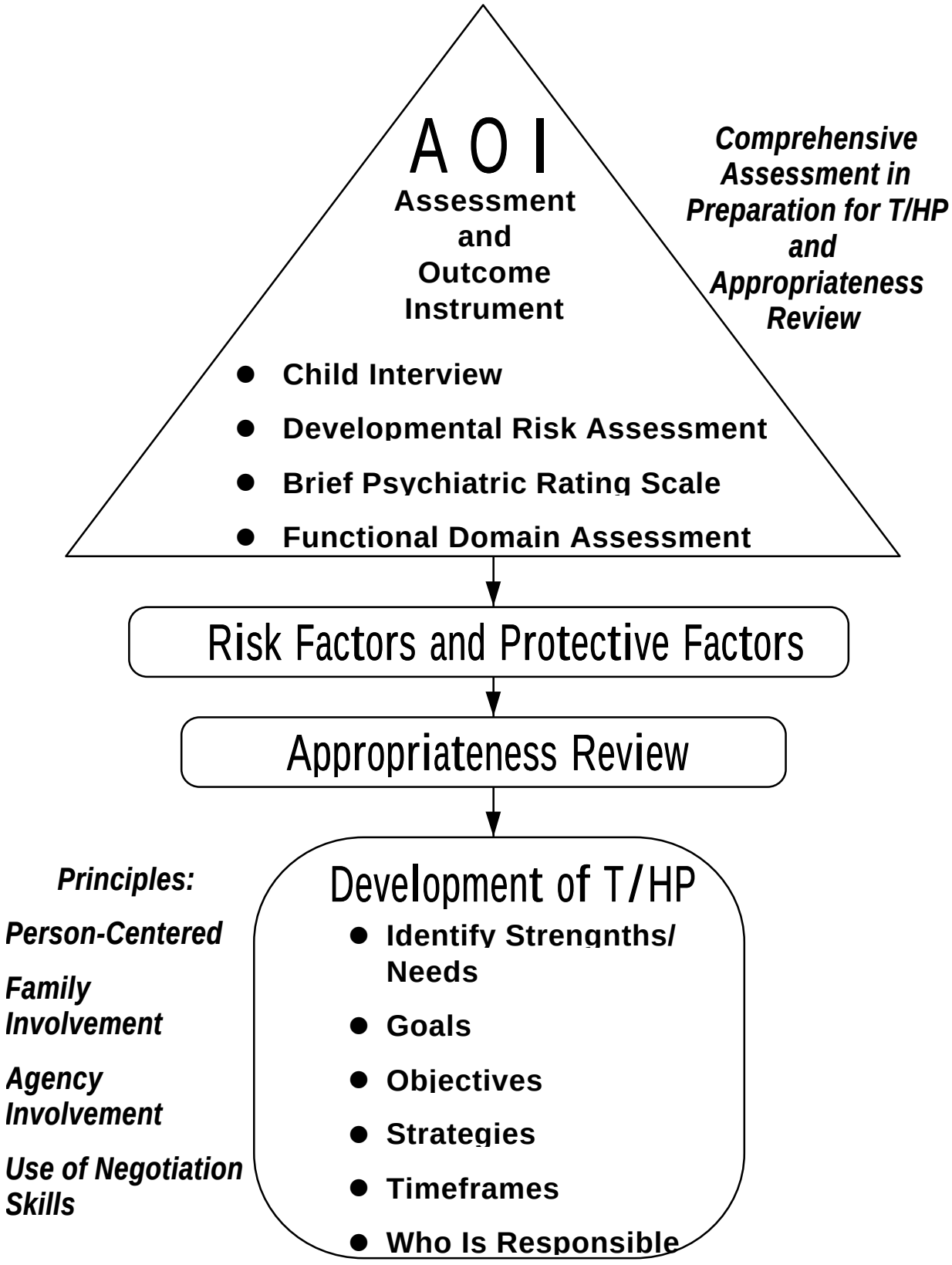
(3) If the Review Officer determines that new evidence would be material to the issues, not merely cumulative, and could not reasonably have been presented at the contested case hearing, he shall conduct a hearing to receive additional evidence.

(4) If the Review Officer determines to afford the parties oral or written argument, he shall notify them of the timing and parameters of the argument. The provisions of G.S. 150B with respect to the reception of evidence shall apply.

(5) Upon completion of review, the Review Officer shall issue a written decision, including findings of fact and conclusions of law. Such decision shall be issued as soon as practical but not more than 45 days after the institution of the appeal provided in Paragraph (a) of this Rule. The Review Officer shall serve a copy of the decision on each party, with copies to the attorneys of record, and shall include with it the notice required by G.S. 122C-199 informing the parties of their right to file a civil action and the 30-day limitation for filing such an action.

History Note: Authority G.S. 122C-3, 122C-112,- 122C-194;
Eff. February 1, 1997;
Transferred and Recodified from I 0 NCA C 18W. 0218 Eff. February 7, 1997.

APPENDIX B OVERVIEW OF THE ASSESSMENT AND OUTCOME INSTRUMENT, APPROPRIATENESS REVIEW AND T/HP AS AN OVERALL PROCESS


A O I
Assessment and Outcome Instrument
Comprehensive Assessment in Preparation for T/HP and Appropriateness Review
Child Interview
Developmental Risk Assessment
Brief Psychiatric Rating Scale
Functional Domain Assessment
Risk Factors and Protective Factors
Appropriateness Review
Development of T/HP
Identify Strengths/ Needs
Goals
Objectives
Strategies
Timeframes
Who Is Responsible
Principles:
Person-Centered
Family Involvement
Agency Involvement
Use of Negotiation Skills

APPENDIX C NEW T/HP REFERENCE